Principal Financial Group

Company Name

Account & Unit Number –

Employee Enrollment & Waiver - NJ

Employee Information

Your Name (Last) (First) (MI)

Social Security Number

Mailing Address (Street)

Date Employed Full-Time (Month, Day, Year)

(City) (State) (ZIP)

Birth Date (Month, Day, Year)

☐ Male
☐ Female

Hrs Wrkd Per Wk

Salary Amount $

Salary Mode ☐ Yr ☐ Wk ☐ Hr ☐ Mo ☐ Bi-wkly

Job Occupation/Class

Location

Do you have an eligible spouse or child? ☐ Yes ☐ No

What is your payroll mode? ☐ Mnthly ☐ Bi-mnthly ☐ Wkly ☐ Bi-wkly

Benefit Options *(You can only elect those coverages offered by your employer.)*

Coverage	Employee		Spouse		Children	
Dental	☐ Elect	☐ Decline	☐ Elect	☐ Decline	☐ Elect	☐ Decline
Vision	☐ Elect	☐ Decline	☐ Elect	☐ Decline	☐ Elect	☐ Decline
Short Term Disability	☐ Elect	☐ Decline				
Long Term Disability	☐ Elect	☐ Decline				
Group Term Life	☐ Elect	☐ Decline	☐ Elect	☐ Decline	☐ Elect	☐ Decline
Voluntary Term Life	☐ Elect	☐ Decline	☐ Elect	☐ Decline	☐ Elect	☐ Decline
	____x Annual Salary		$ ____________		$ ____________	

Have you used nicotine products in the past 12 months? ☐ Yes ☐ No
Has your spouse used nicotine products in the past 12 months? ☐ Yes ☐ No

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

Beneficiary Designation *(Complete if life coverages are elected.)*

Full Name | Relationship

If two or more beneficiaries are named, proceeds shall be paid in equal shares to the surviving beneficiaries, unless specified otherwise. If no beneficiary has been named, any proceeds will be payable as provided by the group policy.

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

Spouse's Name	Birth Date		Social Security Number
		☐ Male ☐ Female	

Name(s) of Child(ren)	Birth Date		Social Security Number	
		☐ Male ☐ Female		☐ Foster Child *
		☐ Male ☐ Female		☐ Foster Child *
		☐ 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.

IMPORTANT -- Complete both sides of this 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. Eligibility for my dependents, over the maximum age, will be verified when claims are submitted.
- If I decline dental coverage, I and/or my dependents may enroll at a later date. However, enrolling late will affect the level of dental benefits.
- If I decline any type of life and/or disability coverages, 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.
- Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.
- 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. 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, make two copies and send the original to Principal Life Insurance Company:

- *One for the employer*
- *One for the employee*

Underwritten by:
Principal Life Insurance Company

Mailing Address:
Des Moines IA 50392-0002

10/26/2005