

Company name: JIMCO MAINTENANCE, INC | Division level: | Account number/unit number: P-28808-1

Employee Information

Your name (last, first, middle initial): | Social security number: |
 Mailing address (street): | Birth date (month/day/year): | male female
 (city): | (state): | (ZIP code): | Do you have an eligible spouse or child? yes no
 Date employed full-time (month/day/year): | Hrs worked per week: | Job occupation/class: | Location:
 Salary amount: | Salary mode: yr wk hr mo bi-wkly | What is your payroll mode? mthly bi-mnthly wkly bi-wkly
 Employer ZIP: 34292 | Employer county: SARASOTA

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

Coverage	Employee	Spouse	Children
Medical	<input type="checkbox"/> elect <input checked="" type="checkbox"/> decline Medical options: _____ (e.g., deductibles, PPO, etc.)	<input type="checkbox"/> elect <input checked="" type="checkbox"/> decline	<input type="checkbox"/> elect <input type="checkbox"/> decline
Dental	<input type="checkbox"/> elect <input type="checkbox"/> decline In the past twelve months, have you, the applicant, had continuous group orthodontia coverage (for yourself and/or your dependents) with a prior carrier? <input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> elect <input type="checkbox"/> decline	<input type="checkbox"/> elect <input type="checkbox"/> decline
Vision	<input type="checkbox"/> elect <input checked="" type="checkbox"/> decline	<input type="checkbox"/> elect <input checked="" type="checkbox"/> decline	<input type="checkbox"/> elect <input type="checkbox"/> decline
Short Term Disability (STD)	<input type="checkbox"/> elect <input checked="" type="checkbox"/> decline If STD Buy-up option is available, check one: <input type="checkbox"/> elect <input type="checkbox"/> decline		
Long Term Disability (LTD)	<input type="checkbox"/> elect <input checked="" type="checkbox"/> decline If LTD Buy-up option is available, check one: <input type="checkbox"/> elect <input type="checkbox"/> decline		
Group Term Life	<input type="checkbox"/> elect <input type="checkbox"/> decline	<input type="checkbox"/> elect <input type="checkbox"/> decline	<input type="checkbox"/> elect <input type="checkbox"/> decline
Supplemental Term Life	<input type="checkbox"/> elect <input checked="" type="checkbox"/> decline \$ _____ or _____ X annual salary		
Voluntary Term Life (VTL)	<input type="checkbox"/> elect <input checked="" type="checkbox"/> decline \$ _____ or _____ X annual salary <input type="checkbox"/> VTL only <input type="checkbox"/> VTL with AD&D	<input type="checkbox"/> elect <input type="checkbox"/> decline <input type="checkbox"/> VTL only <input type="checkbox"/> VTL with AD&D	<input type="checkbox"/> elect <input type="checkbox"/> decline
Have you used nicotine products in the past 12 months?		<input type="checkbox"/> yes <input type="checkbox"/> no	
Has your spouse used nicotine products in the past 12 months?		<input type="checkbox"/> yes <input type="checkbox"/> no	
Does this life insurance replace existing life insurance?		<input type="checkbox"/> yes <input type="checkbox"/> no	
Does the agent know replacement is or may be involved in this life transaction?		<input type="checkbox"/> yes <input type="checkbox"/> no	

Important! If declining any coverage for yourself or any dependent, give reason. Covered under:
 spouse's group coverage individual insurance other coverage offered by my employer
 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.

Important – Complete Page 1 and Page 2.

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

Spouse's name	Birth date	<input type="checkbox"/> male <input type="checkbox"/> female	Social security number
Name(s) of child(ren)	Birth date	<input type="checkbox"/> male <input type="checkbox"/> female	Social security number
	Birth date	<input type="checkbox"/> male <input type="checkbox"/> female	Social security number
	Birth date	<input type="checkbox"/> male <input type="checkbox"/> female	Social security number

Employee Signature (Read and sign below.)

I understand and agree with the following statements:

- My dependents are not eligible for coverages I don't have. I have read and understand the Preexisting Condition Exclusion and the Special Enrollment Rights and know if I refuse medical coverage, I and/or my dependents must wait for the next open enrollment unless I become eligible during a Special Enrollment. If I refuse dental coverage, I and/or my dependents may enroll later but this will affect the level of benefits. If I refuse life and/or disability 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 I refuse coverage, I cannot enroll after retirement.
- If the group policy does not require my contribution, I cannot decline any 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, false statements, omissions and/or material misrepresentations can cause changes in my coverage, including cancellation back to the effective date.
- 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 and disability coverage. Information will not be used for any purposes prohibited by law.
- Explanation of Benefits reflecting claim payments for myself and/or 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.

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.

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Your signature X Date signed _____

Licensed resident agent(s) (individual/firm) _____ Agent's license number _____

Agent's printed name _____

Instructions

After this form is completed and signed, make two copies and send the original to Principal Life Insurance Company:

- Employer – copy of Page 1 only
- Employee – copy of Page 1 and Page 2