**Principal Financial Group**

Please be sure form is complete so enrollment is not delayed.

Underwritten by:
**Principal Life Insurance Company**

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***Enrollment Information – FL***

**Company Name** Jimco Maintenance Inc. **Account Number:** N9608-10335

## A. Employee Information

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

Address (street or P.O. Box | City | State | ZIP code

Date of birth (mo/day/yr) | ☐ male ☐ female | Marital status ☐ single ☐ married ☐ divorced ☐ legally separated

Date of Full-Time employment | Job position/location

Present salary excluding overtime, bonuses, and commissions (check one) $ ☐ yr ☐ mo ☐ wk ☐ hr | Hours per week

**The Principal to Complete**

| Effective date | Effective date |
|---|---|
| ☐ life<br>☐ Dependent life<br>☐ STD ☐ LTD<br>☐ supplemental life<br>dental<br>☐ Member<br>☐ Dependent | medical<br>☐ Member<br>☐ Dependent |

## B. Beneficiary Designation: Complete only if your coverages include group term life insurance.

Beneficiary for employee group term life insurance (Print as "Doe, Mary A.", not "Mrs. John Doe".)

| last name | first name | middle initial | relationship to you |
|---|---|---|---|
| | | | |

Unless otherwise provided herein, if two or more beneficiaries are named, the proceeds shall be paid in equal shares to the named beneficiaries surviving the insured. If no beneficiary has been designated, any proceeds will be payable as provided by the group policy. If additional space is needed for beneficiary designation, please use the Change of Beneficiary form.

## C. Benefit Election: Ask your employer about coverages. Check your election option(s) below.

If you do not elect any or all coverages for yourself and any or all eligible Dependents, complete the Request for Refusal of Group Coverage on the next page and indicate the reason.

**Medical - I elect medical coverage for:**

N/A myself ☐ spouse ☐ child(ren) ______ (indicate number of child(ren) to be covered)

**Dental - I elect dental coverage for:***

☒ myself ☐ spouse ☐ child(ren) ______ (indicate number of child(ren) to be covered)

*You may refuse dental coverage for yourself if allowed by your firm's dental coverage and only if you have other group dental coverage.

**Supplemental Life - If your employer provides supplemental life coverage, do you elect the coverage?**

N/A yes ☐ no

NOTE: If you are applying for Dependent coverage, you must apply for all eligible Dependents (unless coverage is provided under another group coverage).

## D. Dependent Information: Please list your spouse and all eligible children.

Name of spouse | Social security number | Date of birth (mo/day/yr)

| Full name of Dependent child(ren) | Social security number | Date of birth mo | day | yr | Full-Time Student | Foster child | Step child | Handicapped child | Male | Female |
|---|---|---|---|---|---|---|---|---|---|---|
| 1. | | | | | | | | | | |
| 2. | | | | | | | | | | |
| 3. | | | | | | | | | | |

## E. Employee Signature

If the group policy requires that contributions be made by me, I authorize my employer to deduct them from my pay. I have read the notice regarding the Preexisting Condition Exclusion and Special Enrollment Rights, located on the back page of this form, and I understand these provisions. I declare that the information given on this enrollment form is complete and true. I understand an agent cannot guarantee coverage or revise rates, benefits, or provisions without written approval of The Principal.

Signature of employee (do not print) | Date signed

**This section is to be used for refusing group coverage (subject to participation requirements).**

**Company Name** ____________________ **Account Number** ____________

## A. Employee Information

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

I hereby declare that I have been given an opportunity to apply for or I have enrolled for insurance coverage under the above group policy issued by The Principal. I understand the coverage available and I refuse coverage. Check proper box(es) below to refuse coverage.

## B. Refusing Coverages:

**I UNDERSTAND** if I refuse coverage:

(a) my Dependent(s) are not eligible for any coverage for which I am not covered.
(b) I cannot under any conditions re-enter as a retired person.
(c) I (and/or my Dependents) may enroll for medical coverage later; however, unless eligible for special enrollment rights (described on the back page of this form), such enrollment will be deferred until the next annual open enrollment period.
(d) I (and/or my Dependents) may enroll for nonmedical coverage later; however, necessary proof of good health must be provided at my own expense and coverage will not become effective until approved by The Principal. Health conditions which may be present now or develop later may prevent me (and/or my Dependents) from ever being approved for coverage.

## C. Refusal Options:

**I refuse medical coverage for:**
- ☐ myself
- ☐ my spouse
- ☐ my child(ren)

**I refuse dental coverage for:**
- ☐ myself
- ☐ my spouse
- ☐ my child(ren)

**I refuse nonmedical coverage for:**
- ☐ supplemental life
- ☐ other ____________

(Subject to participation requirements)

Name(s) of children I am refusing coverage for:

**Reason for refusing coverage:**
- ☐ individual coverage
- ☐ spouse's group
- ☐ my employer's HMO
- ☐ I am retiring from this firm
- ☐ COBRA or state continuation
- ☐ government coverage
- ☐ other ____________

## D. Employee Signature

I declare that the information given on this form is complete and true.

Signature of employee (do not print) | Date signed | Requested date of change