

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

**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)
<input type="checkbox"/> Male	Hrs Wrkd Per Wk	Salary Amount	Salary Mode	Job Occupation/Class
<input type="checkbox"/> Female	_____	\$ _____	<input type="checkbox"/> Yr <input type="checkbox"/> Wk <input type="checkbox"/> Hr <input type="checkbox"/> Mo <input type="checkbox"/> Bi-wkly	_____
Location	Do you have an eligible spouse or child?		What is your payroll mode?	
_____	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Mnthly <input type="checkbox"/> Bi-mnthly <input type="checkbox"/> Wkly <input type="checkbox"/> Bi-wkly	

**Benefit Options**

<b>Coverage</b>	<b>Employee</b>
Group Term Life	<input type="checkbox"/> Elect *

\* You can not decline any coverage paid in full by your employer.

**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.

**Employee Signature** *(Read and sign below.)*

**I understand and agree with the following statements:**

- If I decline any coverage, 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, 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.

**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