Principal® Financial Group

Mailing Address
Des Moines, IA 50392-0002

Principal Life Insurance Company

Employee Enrollment & Waiver - NC

Company name	Division level	Account number/unit number
Yadkin Valley Economic Development District		

Employee Information

Name			Social security number	
Mailing address (street)			Birth date	☐ male ☐ female
(city)	(state)	(ZIP code)	Do you have an eligible spouse or child? ☐ Yes ☐ No	
Date employed full-time	Hours worked per week		Job occupation/class	Location
Salary amount	Salary mode ☐ yearly ☐ weekly ☐ hourly ☐ monthly ☐ bi-weekly			
What is your payroll mode? ☐ monthly ☐ semi-monthly ☐ weekly ☐ bi-weekly		Employer ZIP 27011	Employer county	

Dental

☐ Elect ☐ Decline Choose from one of the following options.

Option #1

Design description: High Plan

	Employee:	Spouse:	Child:
	☐ Elect ☐ Decline	☐ Elect ☐ Decline	☐ Elect ☐ Decline

Option #2

Design description: Low Plan

	Employee:	Spouse:	Child:
	☐ 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 _____ ☐ other coverage offered by my employer

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

Spouse's name	Birth date	☐ male ☐ female	Social security number	
Name(s) of child(ren)	Birth date	☐ male ☐ female	Social security number	☐ foster child* ☐ disabled or handicapped child **
		☐ male ☐ female		☐ foster child* ☐ disabled or handicapped child **

		☐ male ☐ female		☐ foster child* ☐ disabled or handicapped child **

* If you checked foster child, was the child placed with you by an authorized state placement agency or by order of a court? ☐ Yes ☐ No

** When your child, who is developmentally disabled or physically handicapped, reaches/exceeds the maximum age, an Application to Continue Handicapped Child form must be completed and reviewed to determine eligibility.

Is your spouse employed by this company? ☐ Yes ☐ No

Employee Agreement (Read and sign)

I understand and agree with the following statements:

- My dependents are not eligible for coverages I don't have. My dependents, including step and foster children and any over the maximum age, are eligible based on plan provisions but those over the maximum age will be verified when a claim is filed.
- If I refuse dental coverage, I and my dependents may enroll later but this will affect the level of benefits.
- If I refuse coverage, I cannot enroll after retirement.
- If the group policy does not require my contribution, I cannot decline 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, fraud or intentional misrepresentations can cause changes in my coverage, including cancellation back to the effective 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.
- Explanation of Benefits reflecting claims payments for myself and 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.

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 employee
- One for the employer