



Mailing Address
Des Moines, IA 50392-0002

Principal Life
Insurance Company

Employee
Enrollment &
Waiver - MD

Company name Innovative Staffing Solutions	Division level	Account number/unit number H49306-1
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Employee Information			
Name		Social security number	
Mailing address (street)		Birth date	<input type="checkbox"/> male <input type="checkbox"/> female
(city)	(state)	(ZIP code)	Do you have an eligible spouse or child? <input type="checkbox"/> Yes <input type="checkbox"/> No
Date employed full-time	Hours worked per week	Job occupation/class	Location Beltsville, MD
Salary amount n/a	Salary mode n/a <input type="checkbox"/> yearly <input type="checkbox"/> weekly <input type="checkbox"/> hourly <input type="checkbox"/> monthly <input type="checkbox"/> bi-weekly		
What is your payroll mode? n/a <input type="checkbox"/> monthly <input type="checkbox"/> semi-monthly <input type="checkbox"/> weekly <input type="checkbox"/> bi-weekly		Employer ZIP 20705	Employer county Prince Georges

Dental

Employee: Elect Decline Spouse: Elect Decline Children: Elect Decline

Important! If declining any coverage for yourself or any dependent, give reason. Covered under:

spouse's group coverage individual insurance
 other _____

Eligible Dependent Information (Complete if you have elected benefits for your spouse 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	<input type="checkbox"/> foster child* <input type="checkbox"/> disabled or handicapped child **
		<input type="checkbox"/> male <input type="checkbox"/> female		<input type="checkbox"/> foster child* <input type="checkbox"/> disabled or handicapped child **
		<input type="checkbox"/> male <input type="checkbox"/> female		<input type="checkbox"/> foster child* <input type="checkbox"/> disabled or handicapped 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

** 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.

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. 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 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.
- Any person who, with intent to defraud or knowingly is facilitating a fraud against an insurer, submits an application or files a claim with false or deceptive statements, may be guilty of insurance fraud.
- 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 claims 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 to the best of my knowledge and belief. 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