



Mailing Address  
Des Moines, IA 50392-0002

Principal Life  
Insurance Company

Employee  
Enrollment &  
Waiver - MI

Company name THERAPY STAFF, INC.	Division level	Account number/unit number H51821
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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
Salary amount	Salary mode <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? <input type="checkbox"/> monthly <input type="checkbox"/> semi-monthly <input type="checkbox"/> weekly <input type="checkbox"/> bi-weekly			Employer ZIP		Employer county

**Dental**

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

In the past 12 months, have you, the applicant, had continuous group orthodontia coverage (for yourself and/or your dependents) with a prior carrier?  Yes  No

**Short Term Disability**

Employee:  Elect  Decline

If STD Buy-up option is available, check one:  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	<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 I refuse life 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 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, false statements, omissions, 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 or my dependents will be sent to my home address. I also understand collection of social security numbers for myself 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