Mailing Address:
Des Moines, IA 50392-0002

Principal Life Insurance Company

Employee Dental Enrollment Form

Company Name	Account/Unit Number	Division level

Employee Information

Your name (last) (first) (MI)	Social security number
Mailing address (street)	Home phone number
(city) (state) (ZIP)	Birth date (month, day, year)

☐ male ☐ female | Hrs wrkd per week | Job occupation/class | Location

Do you have an eligible spouse or child? ☐ yes ☐ no | Date employed full-time (month, day, year)

Benefit Options *(You cannot decline any coverage paid in full by your employer.)*

Coverage	Employee	Spouse	Children
Dental	☐ elect ☐ decline	☐ elect ☐ decline	☐ elect ☐ decline

Dental options: ______________________ *(e.g., deductibles, PPO, etc.)*

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

☐ spouse's group coverage ☐ individual insurance ☐ other coverage offered by my employer
☐ other ______________________

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

Spouse's name	Birth date		Social security number
	/ /	☐ male ☐ female	

Name(s) of child(ren)	Birth date		Social security number		
	/ /	☐ male ☐ female		☐ foster child* ☐ step child*	☐ full-time student* ☐ handicapped*
	/ /	☐ male ☐ female		☐ foster child* ☐ step child*	☐ full-time student* ☐ handicapped*
	/ /	☐ male ☐ female		☐ foster child* ☐ step child*	☐ full-time student* ☐ handicapped*
	/ /	☐ male ☐ female		☐ foster child* ☐ step child*	☐ full-time student* ☐ handicapped*

* If you checked foster child/step child, or if your child is over the maximum age or handicapped, see your employer for the necessary form.

Additions/Special Enrollments

Effective date of change:
mo/day/year ______________________

☐ marriage
☐ birth of child
☐ adoption or placement for adoption
☐ court ordered coverage: Please attach a copy of the court order. If you are already enrolled for coverage, and your dependents have declined coverages, your dependent child may enroll, due to a court or administrative order to provide dental coverage.
☐ loss of other coverage: Complete the following if you have lost other dental coverage.

Name of carrier (if applicable)	Name of employer-sponser (if applicable)	Account number
Date coverage ended	Reason coverage ended	

Important – Complete Page 1 and Page 2.

Termination of Benefits

Effective date of change:

- ☐ termination of employment — mo/day/year ________________
- ☐ leave of absence or layoff
- ☐ voluntary withdrawal from the plan
- ☐ no longer meets dependent eligibility requirements (please specify: ________________)
- ☐ divorce (please specify: ________________)

Other Changes

Effective date of change:

- ☐ COBRA continuation — mo/day/year ________________
- ☐ name change from: ________________ to: ________________
- ☐ change of location/unit from: ________________ to: ________________
- ☐ other: ________________

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

I understand and agree with the following statements:

- My dependents are not eligible for any coverage for which I am not covered.
- My dependents, including step and foster children and those over the maximum age, are eligible for coverage based on plan provisions.
- If I decline the benefit options offered, voluntarily withdraw from the plan, and/or do not complete and return this enrollment form to my employer I and/or my dependents may not be eligible for the benefit options offered by my employer.
- Any person who, with intent to defraud or knowing that he or she is facilitating a fraud by submitting an application, enrollment form, or filing a claim containing a false or deceptive statement may be guilty of fraud.
- If the group plan requires that I make contributions, I authorize my employer to deduct them from my pay.

I declare that the information I have completed on this enrollment form is complete and true.

Your signature ________________ Date signed ________________

Please return to your Human Resource Department.

Employer Information (to be completed by Human Resources Department)

Authorized signature of employer ________________ Effective date ________________