Principal Financial Group

FISHEYE SOFTWARE

Account & Unit Number _

Employee Enrollment & Waiver - MA

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)

☐ Male ☐ Female

Hrs Wrkd Per Wk

Salary $

☐ Yr ☐ Mo ☐ Wk ☐ Bi-wkly ☐ Hr

Job Occupation/Class

Location

Do you have an eligible spouse or child? ☐ Yes ☐ No

Benefit Options

Coverage	Employee
Short Term Disability	☐ Elect *
Long Term Disability	☐ Elect *
Group Term Life	☐ 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 Insurance Company.
- 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 Insurance Company.

Your Signature X _____ **Date Signed** _____

Instructions

After this form is completed and signed, send the original to Principal Life Insurance Company and make two copies:

- *One for the employer*
- *One for the employee*