Effective 01/01/2014

DENTAL INSURANCE ENROLLMENT

S ☐ Standard
E ☐ Enhanced

1) ☐ Employee Only
2) ☐ Family
3) ☐ Extended Family (Partner + Child(ren)*

*If box 3 is checked, either box S or E **must** also be checked. (Extended Family Dependent Affidavit must be completed. See HR for form.)

Principal® Financial Group

Company Name
Murray State University

Account number/unit number
H29520-KY (Dental)

Employee Information

Name (Last) (First) (Middle Initial)	Social Security Number	☐ Male ☐ Female	E-Mail
Mailing Address (Street)	Birth Date	Hire Date	Job Occupation/Class
City / State / Zip Code	Do you have an eligible spouse/child? ☐ Yes ☐ No		
	Is your spouse employed by MSU? ☐ Yes ☐ No		

What is your payroll mode? ☐ monthly ☐ bi-weekly

Location **Please circle one:** Murray Ballard Henderson Hopkinsville Madisonville Paducah

Hrs Worked Per Wk ☐ 37.5 ☐ 40

Important! If declining any coverage for 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, children, or extended family member)

Name of Dependents Last First Initial	Date of Birth Mo. Day Yr	Sex M	Sex F	Social Security No.	Relationship to Applicant	
Spouse/Partner's name ☐ **Add** ☐ **Cancel**						
Employee's Dependent/Partner's Dependent ☐ **Add** ☐ **Cancel**						☐ foster child* ☐ disabled or handicapped child **
Employee's Dependent/Partner's Dependent ☐ **Add** ☐ **Cancel**						☐ foster child* ☐ disabled or handicapped child **
Employee's Dependent/Partner's Dependent ☐ **Add** ☐ **Cancel**						☐ foster child* ☐ 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 Agreement (Read and sign)

I understand and agree with the following statements:

- My dependents are not eligible for coverage that 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 must wait for the next open enrollment unless I qualify for a family life circumstance change.
- If the group policy requires my contribution, I authorize my employer to deduct the appropriate amount from my pay.
- I represent that 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. All statements by or on behalf of the insured shall be deemed to be representations and not warranties. 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 that 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 knowingly and with intent to defraud any insurance company or other person who files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.
- 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 represent 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** _____

Mailing Address
Des Moines, IA 50392-0002