



Murray State University - STANDARD

Employee Enrollment & Waiver - KY

Account & Unit Number H29520 - KY -

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)

Hrs Wkrd Per Wk Job Occupation/Class

Male Female

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

What is your payroll mode? Mnthly Bi-mnthly Wkly Bi-wkly

Benefit Options

Coverage	Employee	Spouse	Children
Dental	<input type="checkbox"/> Elect <input type="checkbox"/> Decline	<input type="checkbox"/> Elect <input type="checkbox"/> Decline	<input type="checkbox"/> Elect <input type="checkbox"/> 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 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 *

Male Female Foster Child *

Male Female Foster 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
If your child is over the maximum age and handicapped, see your employer for the necessary form.

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. Eligibility for my dependents, over the maximum age, will be verified when claims are submitted.
- If I decline dental coverage, I and/or my dependents may enroll at a later date. However, enrolling late will affect the level of dental benefits.
- Any person who knowingly and with intent to defraud any insurance company or other person 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.
- If the group policy 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. 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 employer • One for the employee



Murray State University - ENHANCED

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Spouse's Name Birth Date Social Security Number Male Female

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