

LIFE INSURANCE ENROLLMENT FORM



Principal Life
Insurance Company | **Employee
Enrollment &
Waiver - AL**

Company name Bridae Staffing, Inc. Division level 1 Account number/unit number H-4028-1

Employee Information

Your name (last, first, middle initial) _____ Social security number _____

Mailing address (street) _____ Birth date (month/day/year) _____ male female

(city) _____ (state) _____ (ZIP code) _____ Do you have an eligible spouse or child?
 yes no

Date employed full-time (month/day/year) _____ Hrs worked per week _____ Job occupation/class _____ Location _____

Salary amount _____ Salary mode _____ What is your payroll mode?
 yr wk hr mo bi-wkly mthly bi-mnthly wkly bi-wkly

Employer ZIP 366093 Employer county Mobile

Benefit Options (You can only elect those coverages offered by your employer.)

| 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 |
|-------------------|--|--|--|

~~In the past twelve months, have you, the applicant, had continuous group or individual coverage (for yourself and/or your dependents) with a prior carrier? yes no~~

| | | | |
|-------------------|--|--|--|
| Vision | <input type="checkbox"/> elect <input type="checkbox"/> decline | <input type="checkbox"/> elect <input type="checkbox"/> decline | <input type="checkbox"/> elect <input type="checkbox"/> decline |
|-------------------|--|--|--|

| | | | |
|--|--|--|--|
| Short Term Disability (STD) | <input type="checkbox"/> elect <input type="checkbox"/> decline | | |
|--|--|--|--|

~~If STD Buy-up option is available, check one: elect decline~~

| | | | |
|---------------------------------------|--|--|--|
| Long Term Disability (LTD) | <input type="checkbox"/> elect <input type="checkbox"/> decline | | |
|---------------------------------------|--|--|--|

~~If LTD Buy-up option is available, check one: elect decline~~

| | | | |
|-----------------|---|--|---|
| Group Term Life | <input type="checkbox"/> elect <input type="checkbox"/> decline | <input checked="" type="checkbox"/> elect <input type="checkbox"/> decline | <input type="checkbox"/> elect <input type="checkbox"/> decline |
|-----------------|---|--|---|

| | | | |
|-----------------------------------|--|--|--|
| Supplemental Term Life | <input type="checkbox"/> elect <input type="checkbox"/> decline | | |
|-----------------------------------|--|--|--|

~~\$ _____ or _____ X annual salary~~

| | | | |
|--------------------------------------|--|--|--|
| Voluntary Term Life (VTL) | <input type="checkbox"/> elect <input type="checkbox"/> decline | <input type="checkbox"/> elect <input type="checkbox"/> decline | <input type="checkbox"/> elect <input type="checkbox"/> decline |
|--------------------------------------|--|--|--|

~~\$ _____ or _____ X annual salary \$ _____~~

~~VTL only VTL with AD&D VTL only VTL with AD&D~~

~~Have you used nicotine products in the past 12 months? yes no~~

~~Has your spouse used nicotine products in the past 12 months? yes no~~

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

spouse's group coverage individual insurance

other _____

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.

Important - Complete Page 1 and Page 2.

* = sections that must be completed!

Eligible Dependent Information (Complete if you have elected benefits for your spouse and/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 | 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** |
| | | <input type="checkbox"/> male <input type="checkbox"/> female | | <input type="checkbox"/> foster child* <input type="checkbox"/> disabled or handicapped child** |

omit

*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/or my dependents may enroll later but this will affect the level of benefits.
- If I refuse life and/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 I refuse coverage, I cannot enroll after retirement.
- If the group policy does not require my contribution, I cannot decline any 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 and/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 of or a request for 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 claim 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 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