Name: _____ **Activity Name:** _____
LAST FIRST MI

Street Address: _____

City: _____ **State:** _____ **Zip Code**: _____

INSTRUCTIONS

You can use this form to enroll in and change your coverage for Medical, Dental, Disability, Life Insurance, Flexible Spending Account, Health Savings Account and Retirement. Check the boxes that apply to you and fill in the appropriate parts of this form. Sign the form and keep your copy. Return the originals to Human Resources or Benefits representative.

❑ This is a new enrollment

❑ New Hire ❑ Reinstatement ❑ I am changing a coverage election (Complete Part 1)

❑ Change in Status ❑ Open Enrollment ❑ I am waiving or cancelling coverage (Complete Part 2)

PART 1: COVERAGE ELECTION

Check the boxes to indicate which coverage you want. You must fill out an enrollment and beneficiary form for each benefit. If you are enrolling for Medical or Life insurances, also indicate the level of coverage you want.

❑ I want to enroll in the Medical Plan

❑ Medical _____
(Medical Plan Name)

❑ I want to enroll in (check one):

❑ Dental _____

❑ Stand Alone Dental (SAD)

❑ I want to cover (check one):

❑ Employee Only

❑ Employee + Child(ren)

❑ Employee + Spouse

❑ Employee + Family

❑ I want to enroll in the Life Insurance Plan (check all that apply):

❑ Basic Life (1 times pay + $2,000)

❑ Optional Life (1 – 6 times salary) _____ time

❑ Spouse Life: ❑ $10,000 ❑ $25,000 ❑ $50,000

❑ Dependent (Child) Life: ❑ $5,000 ❑ $10,000

❑ I want to enroll in the Disability Plan

❑ I want to enroll in the Flexible Spending Account

❑ I want to enroll in the Health Savings Account

❑ I want to enroll in the Retirement Plan

❑ I want to enroll in the 401(k) Plan (Must self-enroll online at **www.principal.com/welcome** or call **800-547-7754**)

PART 2: WAIVE/CANCEL

Check the boxes below that apply to you. I have received information about the CNIC benefits available to me and I decline coverage at this time. I also understand that there are restrictions in joining at a later date. The benefits booklets explain the late enrollment procedures.

I want to : **❑ waive** **❑ cancel (check all that apply)**

❑ POS II	❑ SAD	❑ Dependent (Child) Life	❑ Flexible Spending Account
❑ HDHP	❑ Basic Life	❑ Long Term Disability	❑ Health Saving Account
❑ HMO	❑ Optional Life	❑ Retirement	
❑ Dental	❑ Spouse Life	❑ 401(k)	

I understand and accept the terms of the Medical, Life and Disability, Retirement, 401(k), Flexible Spending Account and Health Savings Account plans as they affect the elections I have made on this form.

I understand that it is my responsibility to check my Leave and Earning's statement to ensure that I am paying for every benefit that I have requested. If I fail to bring errors to the HR's attention, I may have to wait until Open Enrollment to re-apply. I understand that I am responsible for paying past due premiums to continue coverage.

_____ _____ _____
EMPLOYEE'S SIGNATURE **DATE** **EFFECTIVE DATE OF COVERAGE**

_____ _____
HR REPRESENATIVE SIGNATURE **DATE**