Principal® Financial Group

Employers Dental Services

A Company of the Principal Financial Group

110

Dual Option Employee Enrollment & Waiver Change of Status – AZ

Company name

Account number/unit number

Effective date: ______________

Enrollment – newly eligible | Change of address | COBRA | Cancel
Enrollment – due to change of family status (state reason, below) | Delete dependents | Add dependents
Enrollment – loss of coverage | Change name, new name below

Employee Information

Your name (last) (first) (mi) | Social security number

Mailing address (street or P.O. Box) | 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 (city)

Work telephone | Home telephone

Benefit Options

Coverage	Employee			Spouse			Children		
Indemnity/PPO	elect	decline	cancel	elect	decline	cancel	elect	decline	cancel
In the past twelve months, have you and/or your dependents, had continuous group orthodontia coverage with a prior carrier?								yes	no
EDS Dental Plan	elect	decline	cancel	elect	decline	cancel	elect	decline	cancel

EDS Only – dental facility selected ______________

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

spouse's group coverage | individual insurance

other ______________

Change of status only – reason for change ______________

Change name, former name ______________

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* disabled or handicapped child**
		male female		foster child* disabled or handicapped child**
		male female		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.

Important! Complete Page 1 and Page 2.

Employee Signature *(Read and sign below.)*

For PPO / Indemnity Plan Participants

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 refuse dental coverage, I and/or my dependents may enroll at a later date. However, enrolling late will affect the level of dental benefits. (Does not apply to EDS)
- 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.
- If the group policy does not require my contribution, I cannot decline coverage unless the policy indicates otherwise.
- If the group policy requires my contribution, I authorize my employer to deduct them from my pay.

Your signature X ______________________________ **Date signed** ____________________

For EDS Plan Participants

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 or foster children and those over the maximum age, are eligible for coverage based on plan provisions.
- 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.
- If the group policy does not require my contribution, I cannot decline coverage unless the policy indicates otherwise.
- If the group policy requires my contribution, I authorize my employer to deduct them from my pay.

Eligibility: Eligible dependents will include lawful spouse and unmarried children to age 19, or any unmarried children to age 25, who attend an accredited educational institution on a full time basis and are fully dependent on employee for support or as stated in the employer's master contract. Participants may add dependents midyear if a marriage occurs. Participants may add dependents at date of employer group enrollment. Dependent newborns or adopted children or children placed for adoption will be eligible immediately upon birth or upon adoption or placement for adoption. All newly eligible dependents must be added within 31 days of change. Dependent children must be deleted when they are no longer eligible.

Benefits are available at your selected contracted dental facility ONLY.

I hereby apply for coverage under EMPLOYERS DENTAL SERVICES for which I am now entitled or may become entitled under the provisions of the Master Agreement. I authorize deductions from my earnings at the required contributions towards the cost of the coverage. I certify that I am eligible to participate and that the above information is correct.

Your signature X ______________________________ **Date signed** ____________________

Instructions

After this form is completed and signed, send the original to Principal Life Insurance Company.