\// O O	_								Effe	ctive _	01/01/2014	
VISION INSURANC		□ 1.	Emp	oloye	e On	ıly						
		□ 2.	. Emp	oloye	e + (Child(ren)						
		□ 3.	Emp	oloye	e + 9	Spouse					Minance	
		<u> </u>	Emp	oloye	e + 9	Spouse +	Child(ren)				İ	
		<u> </u>	Exte	ende	d Far	mily Partn	er*					
		☐ 6.	Exte	ende	d Far	mily Partn	er + Child((ren)*				
Principal*						ither box 1 d. See HR		so be ch	ecked. (Exten	ded Fami	ly Dependent	
Financial Company Name			Account number/unit number									
Group Murray State University				H29520-KY (Vision)								
Employee Information			1				T —					
Name (Last) (First) (Middle Initia			Social Security Number						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?	_	cation:	Murray Ballard		Hende		ladisonville		Hrs Wo			
monthly bi-weekly Important! If declining any coverage					•		aducah			4	U	
spouse's group coverage		individua				oth						
Eligible Dependent Information (C	omple	te if you ha	ve elec	ted b	oene	fits for you	ır spouse,	childre	n, or extend	ed fami	ly members.)	
Name of Dependents		Date of E		S	ex			Rela	tionship to			
Last First In Spouse/Extended Family Partner	tial	Mo. Day	Yr.	M	F	Social Se	ecurity No.	A	pplicant			
Add												
Cancel												
Employee's Dependent/Partner's Depende	nt										er child*	
Add Cancel											abled or adicapped child **	
Employee's Dependent/Partner's Depende	nt									_	er child*	
Add										_	abled or adicapped child **	
Employee's Dependent/Partner's Depende												
Add	IL									_	er child* abled or	
Cancel										han	dicapped child **	
* If you checked foster child, do you	provid	e principal s	support	t and	doe	s the child	d(ren) live	with you	u at least 50	% of the	e 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 My dependents are not eligible for 			i't have	. Mv	depe	ndents. inc	ludina step	and fos	ter children a	and anv	over the maximum	
age, are eligible based on plan prov	isions l	but those ove	er the ma	aximı	ım aç	ge will be v	erified wher	n a claim	is filed.	•		
• If I refuse vision 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 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 no 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 f												
cause changes in my coverage, inc	uding o	cancellation b	ack to t	he ef	fectiv	e date.						
 Any person who knowingly and wit any materially false information or of 	n intent	to defraud a	any insu	rance	com	pany or ot	her person	who file	s an applicati	on for in	surance containing	
insurance act, which is a crime.	oriccai	s, for the purp	J03C 01	1111310	aumg	, imorriali	on concern	ing any i	act material ti	icicio cc	minits a maddicin	
 Explanation of Benefits reflecting collection of social security number 											I also understand	
A copy of this form will be as valid a	s the c	riginal.										
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.												
Vous Cianature V	a103, 1	Zorionto, Or	PIOVISIC) I O V	•1010	at WillOII		ato Sic	•			

Mailing Address Des Moines, IA 50392-0002