

The answers to the following questions will dictate how we set up your policy. It's important that all sections are completed accurately. Please return this document along with the Employer Application we've also provided to you.
Your broker will complete [section 7](#).

1. Coverages Requested

Check all coverages you are enrolling in with Principal:

- ☐ Dental ☐ Voluntary Dental ☐ Short Term Disability ☐ Voluntary Short Term Disability
☐ Vision ☐ Voluntary Vision ☐ Long Term Disability ☐ Voluntary Long Term Disability
☐ Basic Life ☐ AD&D ☐ Basic Dependent Life ☐ Voluntary Critical Illness ☐ Voluntary Accident
☐ Voluntary Life ☐ Vol AD&D ☐ Hospital Indemnity (where available)

2. Employer information

Company Legal Name: _____

Is the mailing address for correspondence different than the physical address listed on Employer Application? (bills will be available online only)

☐ No ☐ Yes. Indicate mailing address: _____

Please provide answers to the following questions if they do NOT appear on the employer application:

The U.S. Department of Treasury requires us to 'know our customer' by obtaining information about companies we do business with. Please provide the following details:

Is the company publicly traded, or owned by a 51% majority of more of a different company that is publicly traded on a U.S. Stock Exchange? ☐ Yes ☐ No

Is the company registered with the SEC, a state regulated insurance company, a U.S. federal or state regulated bank, a department or agency of the United States, or of any state? ☐ Yes ☐ No

If No to both of the above questions, provide the following:

Is the company owned by a non-US person or foreign Entity? ☐ Yes ☐ No

Is the company a Non-governmental Organization (NGO) Foundation or Charity? ☐ Yes ☐ No

Is the company a Foreign Financial Institution? ☐ No ☐ Yes

Does any person own a 25% or greater equity interest (direct ownership or beneficial owner) in the Company?

☐ Yes, provide info below ☐ No

If yes: First Name: _____ Last Name: _____ Date of Birth: _____

If yes: First Name: _____ Last Name: _____ Date of Birth: _____

If yes: First Name: _____ Last Name: _____ Date of Birth: _____

Does any other company own a 25% or greater equity interest (direct ownership or beneficial owner) in the Company?

☐ Yes, provide info below ☐ No

If yes: Company Name: _____ Tax ID: _____

If yes: Company Name: _____ Tax ID: _____

Does the company do business outside the U.S.? ☐ Yes ☐ No

If Yes, select any of the following countries where the company does business:

☐ Cuba ☐ Iran ☐ North Korea ☐ Russia ☐ Syria ☐ Ukraine

Employer contact

Provide the contact for administration of this case. An employer can have one contact or multiple.

Who will make decisions for this plan? This is the primary contact for your organization. This person:

- Will receive billing notifications (unless different contact is listed below). **NOTE: all billing statements will be accessed online.**
- Will add or update members online.
- Will grant online access to other contacts as needed.

Name: _____ Email Address: _____

Date of birth (required to setup online access): _____ Phone Number: _____

Who will perform the day-to-day maintenance of the plan? Things like payroll, employee, and billing info on the website.

☐ Same as above ☐ Someone else. Provide the following:

Name: _____ Email Address: _____

Date of birth (required to setup online access): _____ Phone Number: _____

Does this group need a separate contact for billing? Multiple billing locations and location specific billing contacts will be handled in the [billing information](#) section. **This person:**

- Will receive billing notifications. **NOTE: all billing statements will be accessed online.**
☐ Yes. Provide the info below. ☐ No

Name: _____ Email Address: _____

Date of birth (required to setup online access): _____ Phone Number: _____

Does the group have a third-party administrator (TPA)? *signed agreement required*

☐ Yes. ☐ No

***If yes, does this TPA also administer COBRA?**

☐ Yes ☐ No

Employment questions

Total number of company employees (i.e. those on your payroll): _____

Total number of eligible employees (based on eligibility hours): _____

Employers in Colorado, Washington, or Florida: Are you considered a small employer?

☐ Yes ☐ No

(Defined as employed an average of the following number of employees in the past year):

Colorado: 1-100 total employees **Washington:** 1-50 total employees **Florida:** 1-50 eligible employees

Employers in Washington: If you are considered a large employer based on the definition above, please indicate the average number of employees you had in prior calendar year: _____

Legal questions

ERISA information will default to YES for eligible groups. We'll default the Plan Administrator information to the employer's information.

Plan's fiscal year end date (if blank, we'll default to your Policy Anniversary): _____
MM/DD

Dental/Vision: Does the group qualify for COBRA? ☐ Yes, provide info below. ☐ No

***If yes, how does the group want to be billed for COBRA?**

☐ Group bill policyholder ☐ Direct bill COBRA individual

NOTE: For any members currently on COBRA, be sure to submit enrollment that includes the following: Last day worked, COBRA start date, and reason for COBRA continuation

3. Coverage Information:

Case questions

Will domestic partners be covered (assuming same and opposite sex)? (State restrictions may apply)

☐ Yes ☐ No

Did your company have coverage with a prior insurance carrier?

☐ Yes. Provide info below and submit copy of prior carrier bill and booklet/summary ☐ No

***If Yes, complete prior carrier information: Include a copy of prior carrier bill & booklets.**

Carrier Name: _____ **Effective Date:** _____

Termination Date: _____ **Coverages:** _____

Carrier Name: _____ **Effective Date:** _____

Termination Date: _____ **Coverages:** _____

Carrier Name: _____ **Effective Date:** _____

Termination Date: _____ **Coverages:** _____

Dental: If you have a prior carrier, please complete the following:

Did the group's prior dental insurance include orthodontia treatment?

☐ Yes ☐ No

Did your prior dental insurance include a maximum rollover feature (i.e. maximum accumulation, max rollover, max builder)?

☐ Yes (provide prior carrier report showing each employee and dependent maximums accumulated) ☐ No

VTL: If you have a prior carrier, please complete the following:

Spouse Voluntary Term Life rates are based on:

☐ Spouse age (standard option) ☐ Employee Age (allowed for uni-smoker rates)

Will retirees be eligible for coverage (*restrictions apply)? (Life, Dental, Vision)

Please choose one option: ☐ Current Retirees ☐ Future Retirees ☐ Both Current and Future

Definition of retirees (optional):

Coverage questions

Are you utilizing an Electronic Data Interchange (EDI / eFile Vendor)?

☐ No ☐ Yes: Outside Party Service Agreement required.

If Yes to Electronic Data Interchange (eFile), provide details below and note the following:

- You must submit eligibility changes via eService or Group Admin until you're notified the EDI file is fully tested and has been moved to production.
- You will be notified when the EDI file testing begins. Testing cannot begin until your group is fully installed on the Principal system.
- This section excludes EASE and Employee Navigator

Group contact name for EDI: _____

Email address: _____

EDI Vendor: _____

EDI vendor contact name: _____

EDI vendor contact email: _____

Who should be included in EDI communications? (provide names and email):

Who should Data Discrepancy reports be sent to? (provide names and email):

Dental and Vision: Where would you like ID Cards sent?

- ☐ Employer – Mailing Address (not available for groups with less than 10 eligible employees)
- ☐ Employee – Home Address (please note that this option may take longer to receive)
- ☐ Employer – Physical Address from Employer Application (not available for groups with less than 10 eligible employees)

Dental and Vision: If you have affiliate/ subsidiary companies, what company name should appear on ID cards?

- ☐ Not applicable
- ☐ Legal name of parent company for all ID cards
- ☐ Name of company employee works for (enrollment must indicate employer name for each employee)

What is the definition of compensation for benefits based on salary? (Group Term Life, Voluntary Term Life, Short-Term Disability, Long-Term Disability) Ensure the employee enrollment includes full earnings based on option selected below.

- ☐ Base wage (excludes bonus, commissions, overtime)
- ☐ Base wage with bonus *
- ☐ Base wage with commission *
- ☐ Base wage with bonus and commission *
- ☐ W2 *
- ☐ Not applicable

***For bonus/commission/W2, select the year average:**

- ☐ 1 year average
- ☐ 2 year average
- ☐ 3 year average

Long-Term and Short-Term Disability: We offer W2 and FICA services. [Click here](#) to learn more about these services. Will you be signing up for W2/FICA?

- ☐ Yes: the employer will complete agreements **online through eService** after the case is installed.
- ☐ No

Job class setup

Are there any employee groups that need to be excluded from benefits?

- ☐ Yes: Excluded group name: _____
- ☐ No

Waiting periods

When should employees be enrolled for coverage?

- ☐ The day immediately following the final day of the eligibility waiting period
- ☐ The first day of the month coinciding with or following final day of the eligibility waiting period. *Example: If there's a 0 day waiting period, a member hired 1/1 would be effective on 1/1*
- ☐ First day of the insurance month following the final day of the waiting period (by removing coinciding language, employees effective on the first of the month will wait an additional month to be eligible for coverage) . *Example: If there's a 0 day waiting period, a member hired 1/1 would wait until 2/1 to be effective.*

When should coverage be terminated?

- ☐ The last day the employee worked or was part of an eligible class
- ☐ The last day of the insurance month the employee worked or was part of an eligible job class **(Maryland contract state must select this option)**

Does the eligibility waiting period with Principal need to begin after the company Orientation Period?

Affordable Care Act (ACA) Orientation Period: *The ACA rules permit an employment based **orientation period** before the application of eligibility waiting periods. Orientation Periods do not apply to Principal products and are calculated separately.*

- ☐ Yes: provide the info below
- ☐ No

***If Yes, complete this section:**

What is the length of your company Orientation Period? (up to a maximum of 30 days or 1 month is allowed)

Number of Days: _____ **Note:** Eligibility waiting period starts after the orientation periods ends. An employee's hire date will be listed as the day after the orientation period has been satisfied.

How will the waiting periods be set up for this group?

- ☐ Case level – One waiting period for all employees. Provide the following info:

Who will the waiting period apply to?

- ☐ All Employees (time credited towards prior carrier waiting period will be applied)
- ☐ Only to employees hired AFTER the effective date.

How long will the waiting period be?

- ☐ Days _____ ☐ Months _____

(Indicate # of days)

(Indicate # of months)

- ☐ Job class level – waiting periods are determined per job class. Complete details in [Section 6](#)
- ☐ Coverage level – waiting periods are determined by coverage type. Complete details in [Section 6](#)
- ☐ Job class AND Coverage level – waiting periods are determined per coverage for each job class. Complete details in [Section 6](#)
- ☐ This group does not have a waiting period

Contributions

Enter the contribution percentage the employer pays for the employee/dependents.

Dental:	Employee: _____ %	Dependent: _____ %	Retiree*: _____ %
Vision:	Employee: _____ %	Dependent: _____ %	Retiree*: _____ %
Basic Life/AD&D:	Employee: _____ %	Dependent: _____ %	Retiree*: _____ %
Voluntary Life/AD&D:	Employee: _____ %	Dependent: _____ %	
Critical Illness:	Employee: _____ %	Dependent: _____ %	
Accident Coverage:	Employee: _____ %	Dependent: _____ %	
Hospital Indemnity:	Employee: _____ %	Dependent: _____ %	
Short Term Disability:	Employee: _____ %	Bonus Up <input type="checkbox"/>	
	Employee contributions: Pre Tax <input type="checkbox"/> Post Tax <input type="checkbox"/>		
Long Term Disability:	Employee: _____ %	Bonus Up <input type="checkbox"/>	
	Employee contributions: Pre Tax <input type="checkbox"/> Post Tax <input type="checkbox"/>		

4. Billing Information:

What type of billing will you use?

- ☐ Standard Billing: Principal will generate a monthly bill showing all employees for the group. This monthly statement will be accessed online.
- ☐ Self-Accounting: you generate your own bill (requires prior approval and completed agreement)

For Standard billing: Complete the following:

How many bills does the group need?

- ☐ Single bill – only one bill needs to be produced.
- ☐ Multiple bills – the group needs separate bills for units, departments, or locations. Enrollment forms/census must show billing unit name for each employee

If yes to multiple bills, who should receive the billing notification?

- ☐ Company main contact or billing contact (if provided) listed above in section 2
- ☐ Other billing contacts as listed below

Additional Billing / Location Information

Location Name _____

Contact Name: _____

Email Address: _____

Date of birth (required to setup online access): _____

Phone Number: _____

Division Billing?

- ☐ No
- ☐ Yes: Employee Enrollment forms/census must show division name for each employee

Additional Billing / Location Information (continued)

Location Name _____

Contact Name: _____

Email Address: _____

Date of birth (required to setup online access): _____

Phone Number: _____

Division Billing?

- ☐ No
- ☐ Yes: Employee Enrollment forms/census must show division name for each employee

Does the group need their bill broken down by unit, department, or location within the single bill produced (division billing)?

- ☐ No
- ☐ Yes: Employee Enrollment forms/census must show division name for each employee

5. Additional Information:

Are there additional details we should know about you, your employees or insurance coverage? If so, please provide:

Thank you for providing us with these details.

6. Waiting periods by Job Class and/or Coverage:

Job Class Name: _____ Coverages: _____

Job Class / Coverage Waiting Period: (Skip this section if waiting period is the same for all employees)

Who will the waiting period apply to?

- ☐ All Employees (standard option). Employees currently in a waiting period will fulfill the waiting period before becoming eligible.
- ☐ Only to employees hired AFTER the effective date.

How long will the waiting period be?

☐ None ☐ Days _____ ☐ Months _____
(Indicate # of days) (Indicate # of months)

Job Class Name: _____ Coverages: _____

Job Class / Coverage Waiting Period: (Skip this section if waiting period is the same for all employees)

Who will the waiting period apply to?

- ☐ All Employees (standard option). Employees currently in a waiting period will fulfill the waiting period before becoming eligible.
- ☐ Only to employees hired AFTER the effective date.

How long will the waiting period be?

☐ None ☐ Days _____ ☐ Months _____
(Indicate # of days) (Indicate # of months)

[Return to Form](#)

7. Agent and Agency Information (for your broker to complete)

General Agent Information (if applicable):

Company Name _____

Signing Agent Information:

Name _____ Last 4 Digits of SSN: _____

% of Commissions: _____ Email Address: _____

Street/ PO Box: _____

City: _____ State: _____ Zip Code: _____

Agency Information:

Name _____ Last 4 Digits of Tax ID: _____

% of Commissions: _____ Email Address: _____

Street/ PO Box: _____

City: _____ State: _____ Zip Code: _____

Statement code (found on commission statement): _____

Additional Signing Agent Information: complete as needed

Name _____ Last 4 Digits of SSN: _____

% of Commissions: _____ Email Address: _____

Street/ PO Box: _____

City: _____ State: _____ Zip Code: _____

Additional Agency Information: complete as needed

Name _____ Last 4 Digits of Tax ID: _____

% of Commissions: _____ Email Address: _____

Street/ PO Box: _____

City: _____ State: _____ Zip Code: _____

Statement code (found on commission statement): _____