Group Policy Installation Form

Principal Life Insurance Company
Des Moines, IA 50392-0002

The answers to the following questions will dictate how we set up your policy. Once this form is completed, the employer application and any additional forms will be sent out for eSign. ***Your broker will complete*** section 8.

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

Legal name of group (must be full legal name):

____

Doing business as name (if applicable): ______________________________

Federal Tax ID number: ______________________________

Address (Physical Location): ______________________________

____

Is the mailing address for correspondence different than the physical address? (bills are available online only)

○ No ○ Yes. Indicate mailing address: ______________________________

Are employees of any associated business organizations (e.g. parent-subsidiary, brother-sister relationships, affiliated groups, etc.) to be covered? Group meets qualifications outlined in document GP62009**.**

○ Yes. Provide information below. If more space is needed, include on a separate sheet to indicate additional relationships.
○ No

Legal name of group: ______________________________

Federal Tax ID number: ______________________________

Address: ______________________________

Relationship to group: ○ Common Ownership ○ Parent-Subsidiary ○ Brother-Sister Relationships ○ Affiliated Groups

Number of employees: ______________________________

Legal name of group: ______________________________

Federal Tax ID number: ______________________________

Address: ______________________________

Relationship to group: ○ Common Ownership ○ Parent-Subsidiary ○ Brother-Sister Relationships ○ Affiliated Groups

Number of employees: ______________________________

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? ○ Yes ○ No

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: ____________
Email address: ____ Phone: _____________________________________

If yes: First Name: ______________________ Last Name: ____________________________ Date of Birth: ____________
Email address: ____ Phone: _____________________________________

If yes: First Name: ______________________ Last Name: ____________________________ Date of Birth: ____________
Email address: ____ Phone: _____________________________________

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 ☐ Crimean region of Ukraine

Company contacts

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:

- Sign the employer application
- Receive billing notifications (unless different contact is listed below). **NOTE: all billing statements will be accessed online**.
- Add or update members online.
- 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: ____

Can this person have full access to the employer website? This will include employee data like salary and home address.
○ Yes. ○ No

Does this group need a specific 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, there is a specific billing contact. 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)?

O Yes. O No

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

O Yes O No

Employment questions

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

Total number of eligible employees (those that qualify based on eligibility hours/plan provisions): ________

How many hours must an employee work to be eligible for benefits?

- O Standard – An employee must work at least 30 hours per week to be eligible for insurance
- O Other. Indicate number of hours (between 20 and 40): ______________
- O New Mexico contract states – for dental and vision, employees working an average of at least 20 hours per week over a 6 month period may also be eligible for insurance
- O Vermont contract states – Standard – an employee must work at least 17.5 hours per week to be eligible for insurance

Employers in Colorado, Washington, or Florida: Is the group considered a small employer?

O Yes O No

Small employer is defined as: On average, employed 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: Average number of employees group had in prior calendar year: ________

Are any employees not actively at work?

O Yes, information regarding employees Not Actively AtWork must be documented in the Addendum during the Adobe eSign process.

New York contract, complete the info below:

First and Last name: ______________________

Reason not actively at work: ______________________

Last day worked: ______________

Expected return date (if known): ______________

O No

If you have 5-9 eligible lives, and are enrolling in Basic Life, VTL, Short-Term Disability, Long-Term Disability, or Critical Illness: Group primary contact will receive a Field Underwriting Questionnaire for validation and signature completion via Adobe eSign.

To the best of your knowledge has any employee or dependent (if applicable) received medical treatment, consultation, care, or services for, or been diagnosed as having a back condition, cancer, heart disease, kidney disorder, liver disorder, stroke, or other serious or debilitating illness in the last 12 months?

O Yes O No

Are there any employees who are currently not actively at work due to injury or illness or who have been out of work due to injury or illness for at least 5 consecutive working days in the last 12 months?

O Yes O No

Are any covered employees residing outside the United States? O Yes, provide the info below O No

***If yes, provide the following (if multiple employees, provide info below on a separate sheet):**

Name: ______________ Salary: ______________

Employee location: ______________ Expected return date: ______________

Class of employee: ______________________

Legal questions

ERISA information will default to YES for eligible groups and the Plan Administrator will be defaulted to the Group Primary Contact.

Plan's fiscal year end date (if blank, we'll default to your Policy Anniversary). This should be the last day of the month: ______________________
MM/DD

Dental/Vision: Does the group qualify for COBRA? COBRA eligibility is defined as employers who employed 20 or more full and full-time equivalent or part-time employees on at least 50% of the working days in the prior calendar year. ○ Yes, provide info below. ○ No

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

○ Group bill policyholder. COBRA members are included on the group's monthly bill. If group has a COBRA TPA, this option must be selected.
COBRA vendor name (if applicable): ______________________

○ Direct bill COBRA individual. Principal bills the COBRA members directly and won't be included on the group's monthly bill.

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

Does this company have coverage with a prior carrier?
○ Yes. Complete info below and provide copy of prior carrier bill and booklet/summary ○ No

***If Yes, complete prior carrier information: Provide 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)

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

Spouse Critical Illness 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)
○ Yes ○ No

If yes, please choose one option: ○ Current Retirees ○ Future Retirees ○ Both Current and Future

Select coverage(s) retirees are eligible for: ☐ Life ☐ Dental ☐ Vision

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 the group like ID Cards sent? Groups with less than 10 eligible employees will automatically go to the member home address.

○ Employer – Mailing Address (must be 10+ eligible lives)
○ Member – Home Address (please note that this option may take longer to receive)
○ Employer – Physical Address from Employer Application (must be 10+ eligible lives)

Dental and Vision: What company name should appear on ID cards for subsidiary/affiliate companies?

○ 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 group's 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 enroll **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

If you are a school group, complete section 7.

Waiting periods

When should employees be enrolled for coverage?

- ○ 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*
- ○ The day immediately following the final day of the eligibility waiting period
- ○ 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 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 ______________________________ (Indicate # of days) ○ Months ________________________ (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

Employer 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 ☐	
	Employee contributions: Pre Tax ☐ Post Tax ☐		
Long Term Disability:	Employee: __________%	Bonus Up ☐	
	Employee contributions: Pre Tax ☐ Post Tax ☐		

4. Billing Information:

What type of billing will this group use?

- ○ Standard Billing: Principal will generate a monthly bill showing all employees for the group. This monthly statement will be accessed online.
- ○ Self-Accounting: the group generates their 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?

- ○ Group primary contact listed above in section 2
- ○ Other billing contacts as listed below

Additional Billing / Location Information

Billing Unit 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

If yes, include billing division names: ______________________________

____

Additional Billing / Location Information (continued)

Billing Unit 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

If yes, include billing division names: ______________________________

____

For Single Bill: 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

If yes, include billing division names: ______________________________

____

5. Additional Information:

Are there additional details we should know? 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 (time credited towards prior carrier waiting period will be applied)
- ○ Only to employees hired AFTER the effective date

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How long will the waiting period be?

O None O Days ____________________ O 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?

O All employees (time credited towards prior carrier waiting period will be applied)

O Only to employees hired AFTER the effective date

How long will the waiting period be?

O None O Days ____________________ O Months ____________________
(Indicate # of days) (Indicate # of months)

Return to Form

7. School Group Questions (only complete if group is a school)

School groups have unique characteristics that need to be considered when issuing insurance policies and booklets. To help ensure our policies and booklets match your administrative practices and understanding, we need to validate the items below.

Check the statements below that apply to the teachers and other employees employed by the school. If multiple classes, provide info below on a separate sheet if necessary to clarify differences between teachers, administrators, non-exempt employees, etc.

Employee Class ____

Employee classes often differ from employee member groups which are usually defined by product benefit differences. Classes are often defined by different pay schedules, paid by contract, different working schedules, and benefit coverage period differences.

Are employees paid according to a contract?

O Yes:

O No

For VTL, Basic Life, Critical Illness, Accident, and/or Hospital Indemnity coverage, continued:

Does the policyholder plan to allow coverage during the summer break when the employees are not working?

O Yes

O No: if no to this question, AND employee is not paid according to a contract, coverage should not be allowed for any employees that are not teachers if they are not on contract and do not work during the summer break.

For Short Term and/or Long Term Disability

Are employees paid according to a contract?

O Yes

O No

The employees work:

O 12 months of the year

O Only during the academic school year, which is __________ months OR ____________ days. Note that if this option is selected and employees are NOT paid according to a contract, the employees may be considered seasonal, more review will be needed.

If employees only work during the academic school year, and ARE paid to contract, does the policyholder plan to allow coverage during the summer break when the employees are not working? (standard = Y)

O Yes.

- If academic school year is days then school uses 1 divided by working days to deduct pay during the academic year
- If academic school year is months then school uses Standard paycheck to deduct pay during the academic year

O No

8. 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 or NPN: ______________

% 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 or NPN: ______________

% 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): _____________________

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