Principal

Group Policy Installation Form

The answers to the following questions will dictate how we set up your policy. It's very 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 13**.**

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 *Spouse Vol Life rates are based on: ○ Spouse Age (standard option)
○ Employee Age (allowed for uni-smoker rates)

2. Company Main Contact:

Company Legal Name: _____

Company contact for group insurance:

Name: _____

Phone Number: _____

Fax Number: _____

Email Address: _____

3. Billing/ Mailing Information:

Billing type?

○ List Bill: Principal will generate a monthly bill showing all employees for your company
○ Self-Accounting: you generate your own bill (please note restrictions apply and an additional agreement is required

Do you have additional contacts you'd like to name in addition to the contact person listed above (e.g. billing contact or primary online access contact)?

○ No
○ Yes: Fill in Billing Contact and/or Primary Online Access Contact below:

Billing Contact (list one only): If billing contact is with a Third Party, an Outside Party Agreement is required. Contact your broker if you need this agreement.

Name: _____

Phone Number: _____ Fax Number: _____

Email Address: _____

Primary Online Access Contact (only needed if different than company main contact; list one only):

Name: _____

Phone Number: _____ Fax Number: _____

Email Address: _____

Is your Billing / Correspondence Address different from the Physical Address you provided on the Employer Application? *(if you have accident coverage, your billing statement for all coverages will be accessed online)*

○ No
○ Yes: provide the following:

***If Yes, provide your preferred Billing / Correspondence Address:**

Street/ PO Box: _____

City: _____ State: _____ Zip Code: _____

Would you like Separate Bills?

- ○ No: provide the following:

  ***If No, would you like Divisional Billing for your single bill?**

  - ○ No
  - ○ Yes (Employee Enrollment forms/census must illustrate divisions for each employee)

- ○ Yes: provide the following: (Employee enrollment forms/census must illustrate billing unit name for each employee)

  ***If Yes, where would you like the Separate Bills to be sent?**

  - ○ Billing Location
  - ○ Billing Location and Additional Locations. See Section 11 to list additional locations

Should Voluntary Coverages be broken down to match your payroll schedule? ***(This breakdown will be included in your monthly bill.)***

- ○ No
- ○ Yes: provide the following:

  ***If Yes, please select your payroll cycle and provide the requested information:**

  - ○ Weekly (Please provide the last payroll date prior to your Principal coverage effective date)

    MM/DD: _____

  - ○ Bi-Weekly (Please provide the last payroll date prior to your Principal coverage effective date)

    MM/DD: _____

  - ○ Semi-Monthly (Please provide the last 2 payroll dates prior to your Principal coverage effective date)

    MM/DD: _____ MM/DD: _____

4. Enrollment Details:

During your initial enrollment, will you be providing a census via an EXCEL spreadsheet?

- ○ No
- ○ Yes: Electronic Consent Form required

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

- ○ No
- ○ Yes: Outside Party Service Agreement required

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

- ○ Employer – Main Location
- ○ Employer – Billing Address
- ○ Employee – Home Address (please note that this option may take longer to receive)

5. ERISA Information (Employee Retirement Income Security Act of 1974):

Do you have an ERISA plan number?

- ○ No
- ○ Yes: Fill in questions below

ERISA

ERISA Plan Number:_____ **Coverages:** _____

ERISA Plan Number:_____ **Coverages:** _____

Ending date of plan's fiscal year: _____
MM/DD

If Yes to ERISA Number, indicate the Fiduciary and ERISA Plan Administrator:

The Employee Retirement Income Security Act of 1974 (ERISA) requires that each employee benefit plan subject to the Act designate a "Named Fiduciary who shall have authority to control and manage the operation and administration of the plan."

Are the Named Fiduciary and ERISA Plan Administrator an entity OTHER THAN the company legal name? (legal name of company is recommended)

- ○ No (recommended option)
- ○ Yes: provide the information on the following page

If Yes, provide the Named Fiduciary/Plan Administrator:

By listing a specific person or entity other than the company legal name, you will be responsible for contacting us, filing paperwork, and re-confirming ERISA information each time the Fiduciary/Plan Administrator changes. If you are sure you want to name a Fiduciary and Plan Administrator, please fill in the information below:

Name: _____

Phone Number: _____ Email Address: _____

Street/ PO Box: _____

City: _____ State: _____ Zip Code: _____

6. Job Classes and Waiting Periods:

Does your 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.*

- ○ No
- ○ Yes: provide the following:

***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 long must employees work before they are eligible to enroll in benefits (i.e. what is your eligibility waiting period)? *If eligibility waiting periods vary by job class, refer to Section 12.*

Waiting Period Applies To:

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

Waiting Period:

○ None ○ Days _____ (Indicate # of days) ○ Month _____ (Indicate # of months)

After the eligibility waiting period has been satisfied, when are employees eligible to enroll 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
  - ☐ **Check here to remove coinciding wording from above option.** By removing this option, employees effective on the 1st of the month will wait an additional month to be eligible for coverage

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

7. Employer Contributions:

How much is the EMPLOYER contributing towards each benefit being offered to 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: _____ %	
Short Term Disability:	Employee: _____ %		
Long Term Disability:	Employee: _____ %		

***If requesting Retiree Coverage, indicate type of retirees to be covered (Restrictions Apply):**

Please choose one option:

○ Current Retirees ○ Future Retirees ○ Both Current and Future

Optional: List definition of retiree if your company wants additional rules around retiree coverage.

At least _____ years of service and at least _____ years old.

8. Employee Eligibility:

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

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

If above numbers differ, provide class of employee not eligible

(example: part-time, union, etc)**:** _____

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

9. Coverage Information:

Did your company have coverage with a prior insurance carrier?

○ No

○ Yes: Fill in Box Below and submit copy of prior carrier bill and booklet/summary

***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 prior insurance carrier provided your dental insurance, please complete the following:

Did your prior dental insurance include orthodontia treatment?

○ No ○ Yes

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

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

Dental/Vision: Would you like the annual enrollment period set to one month prior to your policy anniversary date?

○ No: provide MM/DD of alternate annual enrollment period: _____

○ Yes: (Standard option)

What is the definition of compensation for benefits based on salary? (Basic Life, Voluntary Term Life, Short-Term Disability, Long Term Disability)

○ Base wage (excludes bonus, commissions, overtime)

○ Base wage with bonus *****

○ Base wage with commission*****

○ Base wage with bonus and commission *****

○ W2*****

***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?

- ○ No
- ○ Yes: agreement required

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.)

- ○ No
- ○ Yes: Fill in Box Below

***If yes, please indicate billing for COBRA**

○ Group bill policyholder ○ Direct bill COBRA individual

**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

Will domestic partners be covered? (State restrictions may apply)

- ○ No
- ○ Yes: Fill in Box Below

***If yes, indicate your preferred definition of a Domestic Partner:**

- ○ Same sex
- ○ Same and opposite sex

10. Additional Information:

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

_____

_____

_____

Thank you for providing us with these details.

11. Additional Company Locations:

***Additional Location Information**

Location Name _____

Street/ PO Box: _____

City: _____ State: _____ Zip Code: _____

Contact Name: _____ Phone Number: _____

Fax Number: _____ Email Address: _____

Number of Employees: _____

Division Billing?

○ No ○ Yes: (Employee Enrollment forms/census must illustrate divisions for each employee)

***Additional Location Information**

Location Name _____

Street/ PO Box: _____

City: _____ State: _____ Zip Code: _____

Contact Name: _____ Phone Number: _____

Fax Number: _____ Email Address: _____

Number of Employees: _____

Division Billing?

○ No ○ Yes: (Employee Enrollment forms/census must illustrate divisions for each employee)

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12. Additional Job Classes:

Job Class Name: _____ **Coverages:** _____

Job Class Specific Waiting Period: (Disregard Waiting Period section if waiting period is same for all job classes)

Waiting Period Applies To:

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

Waiting Period:

○ None ○ Days _____ (Indicate # of days) ○ Month_____ (Indicate # of months)

Job Class Name: _____ **Coverages:** _____

Job Class Specific Waiting Period: (Disregard Waiting Period section if waiting period is same for all job classes)

Waiting Period Applies To:

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

Waiting Period:

○ None ○ Days _____ (Indicate # of days) ○ Month_____ (Indicate # of months)

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

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: _____

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: _____