Mailing Address:
Des Moines, IA 50392-0002

Principal Life Insurance Company

Employer Application for Group Insurance For Small Employer Groups – MD

Underwritten by:
Principal Life Insurance Company
Home Office: Des Moines, IA 50392-0002

This form is for:	New Case Amendment
Advance Premium Received:	$
Requested Effective Date:	

Account Number

Employer Information

Legal name of company

☐ corporation ☐ sole proprietorship
☐ partnership ☐ other _____

Street address

City | State | ZIP code

Telephone number | Fax number and/or Internet mail address

Employee Eligibility

Eligible Employee

☐ All employees working at least 30 hours per week on a regular basis.

☐ Part-time or temporary employees and employees who work fewer than 30 hours per week (unless the rider in the Medical insurance section has been elected for employees working 25 - 30 hours per week), or who are covered under a public (excluding Medicaid) or private health insurance policy or other health benefit arrangement are not eligible.

Ineligible Employee

- An employee who works less than the required number of hours per week is not eligible for insurance.

Total number of Eligible Employees (as defined above): | *Total number of Ineligible Employees (as defined above):*

Excluded Class of Employees *(Some restrictions may apply to small employer groups.)*

Describe any class of employees excluded from the policy.	Number of employees

Employers with Participating Units

Participating unit is an entity that is an affiliate or subsidiary related to the employer through common control or ownership.

Unit name	Address		Number of employees
1.		☐ include unit ☐ exclude unit	
2.		☐ include unit ☐ exclude unit	
3.		☐ include unit ☐ exclude unit	

Excluded Locations

Address(es) of other employer location(s) which are excluded from this policy.	Number of employees

Waiting Period

Applies to:	☐ only employees hired after the effective date of the policy ☐ all employees, including those hired before, on, or after the effective date of this policy
Waiting Period:	☐ 1 month ☐ 3 month ☐ 6 month ☐ other _____
Employees will be eligible the:	☐ day immediately following the final day of the waiting period first of the month following the final day of the waiting period

Medical Insurance

☐ standard health benefit plan for Members and Dependents

☐ standard health benefit plan - PPO for Members and Dependents

Optional riders:

☐ employees working 25 to 30 hours per week are eligible for benefits

☐ deductible credit -- (only available if your firm has prior Medical coverage.) This allows charges incurred during this calendar year by your employees and their Dependents that went toward satisfaction of their deductible under your firm's prior carrier to be applied toward satisfaction of this policy's deductible.

Complete if policy replaces other group insurance:	Name of prior carrier	Effective date	Discontinue date

If more than one carrier provided insurance in the past 12 months, provide carrier name, effective date and discontinue date(s) on a separate sheet of paper, and attach to application.

Dental Insurance

Request for ➢	☐ Employees	☐ Dependents
Does employee contribute to the cost of insurance?	☐ yes ☐ no	☐ yes ☐ no

HMO offered:	☐ yes ☐ no	If yes, number of employees

Complete if policy replaces other group insurance:	Name of prior carrier	Effective date	Discontinue date

Vision Insurance

Request for ➢	☐ Employees	☐ Dependents
Does employee contribute to the cost of insurance?	☐ yes ☐ no	☐ yes ☐ no

Complete if policy replaces other group insurance:	Name of prior carrier	Effective date	Discontinue date

Term Life Insurance *(Proof of Good Health may be required before employee insurance can become effective.)*

Request for ➢	☐ Employee Basic Term Life	☐ Supplemental Term Life	☐ Dependent Term Life
Basic Term Life with the following features:	☐ Basic AD&D	☐ Supplemental Term Life ☐ Supplemental AD&D	
Does employee contribute to the cost of insurance?	☐ yes ☐ no	☐ yes ☐ no	☐ yes ☐ no
Voluntary Term Life Insurance, applies to:	☐ Employee (100% contributory insurance)		☐ Spouse ☐ Child
Complete if policy replaces other group insurance:	Name of prior carrier	Effective date	Discontinue date
Employees not Actively at Work and Dependents in a Period of Limited Activity:	List all employees who are not Actively at Work and Dependents in a Period of Limited Activity.		

Disability Insurance *(Proof of Good Health may be required before employee insurance can become effective.)*

Request for ➢	☐ Employee Short Term Disability	☐ Employee Long Term Disability
Does employee contribute to the cost of insurance?	☐ yes ☐ no	☐ yes ☐ no
Employees not Actively at Work:	List all employees who are not Actively at Work	
State specific information: *(Short Term Disability only)*	Are there employees located in any of the states listed below *(policies offered in these states are supplemental)*? ☐ yes ☐ no *(if yes, indicate the number of employees for each state.)*	

California	Hawaii	New Jersey	New York	Rhode Island

Unemployment Insurance or Department of Labor Number

Print

210

ERISA

Employer tax ID number	Plan number

The Employee Retirement Income Security Act of 1974 (ERISA) requires each employee benefit plan designate a named fiduciary that shall have authority to control and manage the operation and administration of the plan. The named fiduciary, if other than the employer, must sign this application. For purposes of ERISA, the employer is the plan administrator.

It is understood that Principal Life shall not be responsible for any tax or legal aspects of the plan. The employer assumes responsibility for these matters. The employer acknowledges that they have counseled to the extent necessary with selected legal and tax advisors. The obligations of Principal Life shall be governed solely by the provisions of its contracts and policies. Principal Life shall not be required to look into any action taken by the named fiduciary or the employer and shall be fully protected in taking, permitting, or omitting any action on the basis of the employer's actions. Principal Life shall incur no liability or responsibility for carrying out actions as directed by the named fiduciary or the employer.

It is further understood that by signing this application, the employer is purchasing insurance and not making an investment. No reserves, undeclared or unpaid experience premium refunds, or interest with respect to claim payments, nor claim proceeds themselves shall be considered plan assets under ERISA.

COBRA/State Continuation *(List everyone currently under continuation provisions.)*

Employee or Dependent name		Employee or Dependent name	
	☐ State Cont. ☐ COBRA		☐ State Cont. ☐ COBRA
	☐ State Cont. ☐ COBRA		☐ State Cont. ☐ COBRA

Agreement and Signatures

- The employer has been informed of the minimum participation and contribution requirements. The employer agrees that insurance applied for shall not become or remain effective unless, a) participation and contribution requirements are met and b) the application and any attached page(s) are received, accepted, and approved by Principal Life.
- If this application is accepted, all group policies will be combined and treated as one policy for the purpose of determining any experience premium refund.
- The preexisting condition restrictions for medical and/or long term disability insurance have been explained to and understood by the employer.
- The employer has been informed that if choosing any medical option, benefits will be reduced when Hospital Admission Review or Pretreatment/Presurgery Review requirements are not met.
- Premium payment will be monthly unless otherwise indicated.
- Acceptance by the employer of any policy or policies issued with this application shall constitute approval of any corrections, additions, or changes specified in the space "For Principal Life Use Only" or as otherwise indicated on this application.
- Your agent or broker cannot change or waive any provision of this application or the policy or policies without the written approval of an officer in the home office.
- The employer acknowledges and understands that if this application is approved, the Group Policy will determine all rights and benefits.
- The person signing has legal authority to bind the employer for whom application is being made.

NOTE: If Principal Life determines, due to requirements of law or because of our own underwriting criteria, to issue our group insurance through a multiple-employer group insurance trust, the employer hereby subscribes to and agrees to the terms of that trust.

Employer (company name)

Signed by (must be an officer)	Officer's title	Date signed
Licensed resident agent(s) *(individual/firm)*	Agent's license number	Date signed
Signature of Soliciting Agent(s) *(If more than one, all must sign.)*		Date signed
Witness		Date signed

For Principal Life Use Only