Principal Financial Group

Mailing Address:
711 High Street
Des Moines, IA 50392-0002

Principal Life Insurance Company

Employer Application for Group Insurance - NY

This form is for: ☐ new case ☐ amendment Account number _____

Requested effective date: _____ Advance premium received $ _____

Employer Information

Legal name of company (include dba)

☐ C-corporation ☐ S-corporation ☐ limited liability company ☐ partnership ☐ sole proprietorship
☐ other _____

Physical address (street)	City	State	ZIP code

Mailing address (P.O. box)	City	State	ZIP code

Contact	Telephone number	FAX number	E-mail address

Nature of business	SIC code	Federal tax ID number	Number of years in business

Have you been insured by Principal Life Insurance Company previously? ☐ no ☐ yes

If yes, when and under what name? _____

Has the company been denied credit within the past two years, ever filed for bankruptcy, or is the firm now in the process of (or considering) filing for bankruptcy? ☐ no ☐ yes (attach an explanation)

Complete the following if this coverage replaces other group insurance. Provide a copy of the most recent billing.

Note: Include prior carrier information for past three years.

Name of Carrier	Coverage(s)	Effective Date	Termination Date

Employers with Participating Units

Are employees of any associated business organizations (e.g. parent-subsidiary, brother-sister relationships, affiliated groups, etc.) to be covered? ☐ no ☐ yes If yes, please list the affiliate or subsidiary below.

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

Unit name/address/federal tax ID	Nature of business	Relationship to company		Number of employees
1.			☐ include unit ☐ exclude unit	
2.			☐ include unit ☐ exclude unit	

Request for Benefits

☐ vision ☐ short term disability ☐ long term disability

☐ basic term life Options: ☐ basic term accidental death and dismemberment ☐ dependent term life
☐ supplemental term life ☐ supplemental term accidental death and dismemberment

☐ voluntary term life Options: ☐ accidental death and dismemberment ☐ accelerated death benefits

☐ dental

If you are offering multiple dental benefit options to employees, attach a list of which benefit options each employee elects.

Waiting Period/Effective Date Provisions 210

Currently eligible (employees working the required number of hours on or before the effective date of new case/new coverage with Principal Life):	Waiting Period ☐ 1 month ☐ 30 days ☐ 60 days ☐ 3 months ☐ 90 days ☐ 6 months ☐ other _____ Note: If you wish all employees to have the same waiting period, the waiting period for currently eligible should be marked the same as futures. Employees who have already met the waiting period above do not have to meet it again if continuously working.
Futures (employees hired the day after the effective date of coverage or later):	Waiting Period ☐ 1 month ☐ 30 days ☐ 60 days ☐ 3 months ☐ 90 days ☐ 6 months ☐ other _____
Employees will be eligible/terminate on the:	☐ day immediately following the final day of the waiting period or change. Termination of coverage will be on the last day employee worked or was part of an eligible class. ☐ first day of the insurance month coinciding with or next following the final day of the waiting period or change. Termination of coverage will be the last day of the insurance month in which the employee worked or was part of an eligible class.

Employer Contribution

Complete this table listing the percentage of premium the employer will pay for each employee.

	Vision	Short term disability (STD)*	Long term disability (LTD)*	Basic term life	Voluntary term life	Supplemental term life	Dental
Employee	____%	____%	____%	____%	____%	____%	____%
Dependent	____%	N/A	N/A	____%	____%	N/A	____%
Retired	____%	N/A	N/A	____%	____%	____%	____%

Note: Retired coverage not available for all coverages.

*If employees contribute to the cost of STD or LTD insurance, are these contributions made on a
☐ pre-tax or ☐ post-tax basis?

Definition of Compensation (Life, STD, LTD)

☐ base wage (excludes bonus, commission, overtime, etc.)
☐ base wage (with bonus)
☐ base wage (with commission)
☐ base wage (with commission and bonus)
☐ other _____

☐ W-2 (1 year average)
☐ W-2 (2 year average)
☐ W-2 (3 year average)
☐ contract salary

Should the definition differ by class? ☐ no ☐ yes, explain _____

When will salary information be updated? ☐ date of change ☐ annually on the following date: _____
☐ policy anniversary ☐ other _____

Employee Eligibility 210

Eligible Employees

☐ an employee must work at least 30 hours per week to be eligible for insurance.

☐ other _____ (if agreed to by the home office of Principal Life)

Ineligible Employees

- An independent contractor (unless required by law)
- An employee who works less than the required number of hours per week, or is employed as a temporary or seasonal employee, is not eligible for insurance.

Total number of employees (full and part-time):	Total number of eligible employees (full and part-time):

Describe any class of employees or location(s) excluded from coverage.

Complete the following sections for coverages being requested.

Life

If you are a group with 51 or more employees requesting group term life insurance, do you want insurance for retirees?

☐ no ☐ yes If yes, ☐ your current retirees ☐ your future retirees

Disability

If you are requesting short term disability coverage, are there employees working in any of the states listed below (policies offered in these states are supplemental)? ☐ no ☐ yes

If yes, indicate the number of employees for each state in the box.

California	Hawaii	New Jersey	New York	Rhode Island

Life/Disability

If requesting life or disability insurance, are there any employees not actively at work and dependents (if dependent life insurance is requested) in a period of limited activity? ☐ no ☐ yes If yes, please list employees and dependents not actively at work as well as their last day worked and expected return to work date. _____

Dental

If dental insurance is requested, do you want to insure retirees? ☐ no ☐ yes

If yes, ☐ your current retirees ☐ your future retirees

If you are replacing dental insurance, did your prior dental coverage include benefits for orthodontia treatment?

☐ no ☐ yes

Dental/Vision

COBRA eligibility is defined as employers who employed 20 or more full or part-time employees on at least 50% of the working days in the prior calendar year. Do you meet the eligibility definition? ☐ no ☐ yes

If COBRA applies, please select desired billing option: ☐ group bill policyholder ☐ direct bill continuee (individual)

If you currently have anyone on COBRA, please submit enrollment form with qualifying event date noted.

All Coverages **210**

Employer elects to be:

☐ standard accounting

☐ self accounting (not available for medical coverage)

ERISA plan number: ____ Coverage: _____

ERISA plan number: ____ Coverage: _____

If more, attach list with ERISA plan number and coverage.

Plan administrator: _____

Plan sponsor: _____

Agent for legal services: _____

Ending date of plan's fiscal year: _____

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."

If this plan is subject to ERISA and the Named Fiduciary is other than the employer, fill in the information below. Principal Life may not be designated as Named Fiduciary.

The "Named Fiduciary" shall be: _____

Designation as Named Fiduciary is accepted. (Required only if the "Named Fiduciary" is an individual.)

By _____

Title _____

Agreement and Signatures

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.

- The employer has been informed of the eligibility requirements. The employer agrees that insurance applied for shall not become effective or remain effective unless the employer: a) is actively engaged in business for profit within the meaning of the Internal Revenue Code, or is established as a legitimate nonprofit corporation within the meaning of the Internal Revenue Code; and b) meets the participation and contribution requirements.
- The employer agrees that insurance applied for shall not become effective unless the application and any attached page(s) are received, accepted and approved by Principal Life.
- If this application is accepted, all non-contributory group policies will be combined and treated as one policy for the purpose of determining any experience premium refund.
- The preexisting condition restrictions for long term disability insurance have been explained to and understood by the employer.
- Actively at work and period of limited activity for life coverage have been explained to and understood by the employer.
- The employer understands receipt and deposit of advanced payment is not a guarantee of coverage. If a policy is issued from this application and is accepted by the proposed policyholder, we will apply the premium deposit to the first premium due for such policy. If no policy is put into force, the premium deposit will be refunded.
- Premium payment will be monthly unless otherwise indicated.

Agreement and Signatures (continued) 210

- Acceptance by the employer of any policy or policies issued with this application shall constitute acceptance 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 of Principal Life in the home office.
- The employer acknowledges and understands that if this application is approved, the group policy will determine all rights and benefits. This application will be attached to and made a part of the group policy.
- The person signing this form for the employer has legal authority to bind the employer for whom application is being made.
- The employer agrees to make timely notification of any employee termination, status change, or other material changes that may affect the eligibility of employees or their dependents. Timely notification is no more than 31 days past the actual date of such change.
- The employer understands that failure to pay premium when due will be considered a default in premium payment and coverage will terminate at the end of the grace period. If coverage is terminated for nonpayment of premium, premium through the grace period is due and will be collected. The employer understands that coverage may also be terminated for other reasons as provided in the group policy.
- The employer understands their rights and responsibilities if electing self accounting status.

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.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for **accident and health** insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

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

For Principal Life Use Only

Print

Principal Financial Group

Mailing Address:
Des Moines, IA 50392-0002

Principal Life Insurance Company

Compensation Disclosure Addendum

As a result of this sale, the broker may receive commissions, administrative service fees, other compensation including non-cash compensation, and bonuses based on factors such as total premium volume and persistency or profitability of the business. The cost of this compensation may be directly or indirectly reflected in the premium or fee for the product(s) you have applied for on the attached employer application form. This compensation is in addition to any compensation the broker may receive from you. Contact the broker for further details.