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. 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 12.

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. This is the primary contact for your organization. This person:

- Will receive billing notifications. **NOTE: all billing statements will be accessed online.**
- Can add or update members online.
- Can grant online access to other contacts as needed.

Name: _____

Phone Number: _____

Email Address: _____

3. Billing Information:

Billing type?

○ Self-Accounting: you generate your own bill (please note restrictions apply and an additional agreement is required)
○ Standard Billing: Principal will generate a monthly bill showing all employees for your company. This monthly statement will be accessed online.

Additional billing options for your standard bill:

Single bill broken down by unit / department / location (division billing)?

○ No
○ Yes (Employee Enrollment forms/census must show division name for each employee)

Separate bills broken down by unit / department / location?

○ No
○ Yes: the monthly statements will be accessed online. Enrollment forms/census must show billing unit name for each employee

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

○ Company main contact listed above in section 2
○ Other billing contacts as listed below

Additional Billing / Location Information

Location Name _____

Contact Name: _____

Phone Number: _____

Email Address: _____

Division Billing?

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

Additional Billing / Location Information (continued)

Location Name _____

Contact Name: _____

Phone Number: _____

Email Address: _____

Division Billing?

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

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 (EDI / eFile Vendor)?

- ○ No
- ○ Yes: Outside Party Service Agreement required and complete fields below:

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.

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 shipped?

- ○ Employer – Physical Address from Employer Application
- ○ Employee – Home Address (please note that this option may take longer to receive)

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

- ○ Legal name of parent company for all ID cards
- ○ Name of company employee works for (enrollment must indicate employer name for each employee)

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

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

6. Job Classes and Waiting Periods:

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 11.*

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 ***(Maryland contract state must select this option)***

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.

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: _____ %	Bonus Up ☐	
Long Term Disability:	Employee: _____ %	Bonus Up ☐	

***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

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: _____

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)

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

***If yes, do you have a COBRA Third Party Administrator?**

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

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 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)

Return to Form

12. 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: _____

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): _____