

Mailing Address:
Des Moines, IA 50392-0002

Principal Life Insurance Company

Employer Application for Group Insurance – TX

This form is for: new case amendment Account number _____
 Requested effective date: _____ Advanced premium received \$ _____

You have the option to choose a Consumer Choice Health Benefits Insurance Plan (CCP) that, either in whole or in part, does not provide state-mandated health benefits normally required in accident and sickness insurance policies in Texas. This standard health benefit plan may provide a more affordable health insurance policy for you although, at the same time, it may provide you with fewer health benefits than those normally included as state-mandated health benefits in policies in Texas. If you choose this standard health benefit plan, please consult with your insurance agent to discover which state-mandated health benefits were excluded in the policy.

Employer Information

Legal name of company (include dba) _____

<input type="checkbox"/> corporation	<input type="checkbox"/> partnership	<input type="checkbox"/> sole proprietorship	<input type="checkbox"/> other _____
Physical address (street)	City	State	ZIP code
Mailing address (PO 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

If employees of any associated business organizations (e.g. parent-subsidiary, brother-sister relationships, affiliated groups, etc.) are to be covered, 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

Medical plan number(s) _____ PCS plan number _____
 Illustrated in proposal number _____ Version number _____
 dental 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
 medical: Do you want insurance for employees employees and dependents
 PPO number(s)/name(s) _____

If multiple PPOs are elected, please include a list showing which employees are utilizing each PPO.
 network choice. Attach list of which network each employee elects. (not available for CCP plans)
 benefit choice. Attach list of which benefit each employee elects. (not available for CCP plans)

Waiting Period/Effective Date Provisions

Initials (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	3 months	6 months	Other _____
	Note: If you wish all employees to have the same waiting period, the waiting period for initials 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	3 months	6 months	Other _____
	Employees will be eligible on the:	day immediately following the final day of the waiting period first day of the insurance month (insurance month coincides with premium due date)			

Employer Contribution

	Employee	Dependent
Dental	_____ %	_____ %
Vision	_____ %	_____ %
Short term disability (STD)*	_____ %	
Long term disability (LTD)*	_____ %	
Basic term life and accidental death and dismemberment	_____ %	
Dependent term life		_____ %
Supplemental term life and accidental death and dismemberment	_____ %	
Voluntary term life	_____ %	_____ %
Medical	_____ %	_____ %

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

Employee Eligibility

Eligible Employee

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

For Groups not subject to small employer legislation

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

Ineligible Employee

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

Do you have employees or their dependents residing: (check all that apply)

- outside the United States?
- in Hawaii (not eligible for medical insurance)
- in New York? How many? _____

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
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Life/Disability

If requesting life or disability insurance, list all employees not actively at work and dependents (if dependent life insurance is requested) in a period of limited activity.

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

Medical

Do you offer medical coverage to your employees through another carrier? no yes, number covered? _____

TEFRA eligibility is defined as employers who employed 20 or more full and/or part-time employees for 20 or more calendar weeks in the current or preceding year. If this requirement is met, the group is TEFRA eligible and Principal Life will pay primary to Medicare.

Do you meet the eligibility definition? no yes
 If you are a group with 51 or more employees requesting medical insurance, do you want insurance for retirees?
 no yes If yes, your current retirees your future retirees

Medical/Dental/Vision

COBRA eligibility is defined as employers who employed 20 or more full and/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 individual bill continuee
 If you currently have anyone on COBRA, please submit enrollment form with qualifying event date noted.

ERISA plan number _____

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 _____

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.

Agreement and Signatures

- 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 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 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.
- 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 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.
- 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.

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, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement, may be guilty of insurance fraud. Fraud or misrepresentation may be grounds for nonrenewal or termination under the terms of the group policy.

Employer (company name)

Signed by (must be an officer)	Officer's title	Date signed
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Licensed resident agent(s) (<i>individual/firm</i>)	Agent's license number	Date signed
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Signature of soliciting agent(s) (<i>If more than one, all must sign.</i>)	Date signed
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For Principal Life Use Only