

Mailing Address:  
Des Moines, IA 50392-0002

**Principal Life Insurance Company**

**Employer Application for Group Insurance – NJ**

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

**Employer Information**

Legal name of company (include dba) \_\_\_\_\_

corporation      partnership      sole proprietorship      other \_\_\_\_\_

Street address \_\_\_\_\_      Billing address \_\_\_\_\_

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	include unit exclude unit	Number of employees
1. _____	_____	_____	include unit exclude unit	_____
2. _____	_____	_____	include unit exclude unit	_____

**Request for Benefits**

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

**Waiting Period/Effective Date Provisions**

Waiting Period:	1 month          3 months          6 months          other _____
Applies to:	only employees hired after the effective date all employees, including those hired <u>before</u> , <u>on</u> , or <u>after</u> the effective date
Employees will be eligible on the:	day immediately following the final day of the waiting period or change first of the insurance month coinciding with or next following the final day of the waiting period or change

**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	_____ %	

\*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.

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): \_\_\_\_\_

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
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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.

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**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

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**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.

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**All Coverages**

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.

- 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 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 includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

To the best of my knowledge and belief, I declare that the information I have completed on this application form is complete and true.

\_\_\_\_\_  
Employer (company name)

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

**For Principal Life Use Only**