Principal® Financial Group

Mailing Address:
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: _____

Advanced premium received $ _____

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 | No. of years in business

Nature of business | SIC code | Federal tax ID no.

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 Insurance Company (The Principal®)]

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

Excluded Class of Employees

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

Employers with Participating Units

If employees of any associated business organizations are to be covered (i.e. parent-subsidiary, brother-sister relationships, affiliated groups, etc.), 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	Nature of business	Relationship	☐ include unit ☐ exclude unit	Number of employees
1.				
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 insurance month following the final day of the waiting period

Dental Insurance (Employer sponsored or Voluntary)

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

ERISA

Employer tax ID number	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. The Principal 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 The Principal 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 The Principal shall be governed solely by the provisions of its contracts and policies. The Principal 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. The Principal 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	☐ State Cont. ☐ COBRA	Employee or Dependent name	☐ State Cont. ☐ COBRA
	☐ State Cont. ☐ COBRA		☐ State Cont. ☐ COBRA

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 The Principal.
- 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.
- 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 The Principal 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 The Principal 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 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
Witness		Date signed

For The Principal Use Only