



The answers to the following questions will dictate how we set up your policy. Once this form is completed, the employer application and any additional forms will be sent out for eSign. **Your broker will complete section 8.**

## 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       Hospital Indemnity (*where available*)

## 2. Employer information

Legal name of group (must be full legal name):

\_\_\_\_\_

Doing business as name (if applicable): \_\_\_\_\_

Federal Tax ID number: \_\_\_\_\_

Address (Physical Location): \_\_\_\_\_

\_\_\_\_\_

Is the mailing address for correspondence different than the physical address? (bills are available online only)

- No       Yes. Indicate mailing address: \_\_\_\_\_

Are employees of any associated business organizations (e.g. parent-subsidiary, brother-sister relationships, affiliated groups, etc.) to be covered? Group meets qualifications outlined in document [GP62009](#).

- Yes. Provide information below. If more space is needed, include on a separate sheet to indicate additional relationships.  
 No

Legal name of group: \_\_\_\_\_

Federal Tax ID number: \_\_\_\_\_

Address: \_\_\_\_\_

Relationship to group:  Common Ownership     Parent-Subsidiary     Brother-Sister Relationships     Affiliated Groups

Number of employees: \_\_\_\_\_

Legal name of group: \_\_\_\_\_

Federal Tax ID number: \_\_\_\_\_

Address: \_\_\_\_\_

Relationship to group:  Common Ownership     Parent-Subsidiary     Brother-Sister Relationships     Affiliated Groups

Number of employees: \_\_\_\_\_

The U.S. Department of Treasury requires us to ‘know our customer’ by obtaining information about companies we do business with. Please provide the following details:

Is the company publicly traded, or owned by a 51% majority of more of a different company that is publicly traded on a U.S. Stock Exchange?  Yes  No

Is the company registered with the SEC, a state regulated insurance company, a U.S. federal or state regulated bank, a department or agency of the United States, or of any state?  Yes  No

**If No to both of the above questions, provide the following:**

Is the company owned by a non-US person or foreign Entity?  Yes  No

Is the company a Non-governmental Organization (NGO) Foundation or Charity?  Yes  No

Is the company a Foreign Financial Institution?  Yes  No

Does any person own a 25% or greater equity interest (direct ownership or beneficial owner) in the Company?

Yes, provide info below  No

If yes: First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Email address: \_\_\_\_\_ Phone: \_\_\_\_\_

If yes: First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Email address: \_\_\_\_\_ Phone: \_\_\_\_\_

If yes: First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Email address: \_\_\_\_\_ Phone: \_\_\_\_\_

Does any other company own a 25% or greater equity interest (direct ownership or beneficial owner) in the Company?

Yes, provide info below  No

If yes: Company Name: \_\_\_\_\_ Tax ID: \_\_\_\_\_

If yes: Company Name: \_\_\_\_\_ Tax ID: \_\_\_\_\_

Does the company do business outside the U.S.?  Yes  No

**If Yes, select any of the following countries where the company does business:**

Cuba  Iran  North Korea  Russia  Syria  Crimean region of Ukraine

## Company contacts

Provide the contact for administration of this case. An employer can have one contact or multiple.

Who will make decisions for this plan? This is the primary contact for your organization. This person will:

- Sign the employer application
- Receive billing notifications (unless different contact is listed below). **NOTE: all billing statements will be accessed online.**
- Add or update members online.
- Grant online access to other contacts as needed.

Name: \_\_\_\_\_

Email Address: \_\_\_\_\_

Date of birth (required to setup online access): \_\_\_\_\_

Phone Number: \_\_\_\_\_

Who will perform the day-to-day maintenance of the plan? Things like payroll, employee, and billing info on the website.

Same as above  Someone else. Provide the following:

Name: \_\_\_\_\_

Email Address: \_\_\_\_\_

Date of birth (required to setup online access): \_\_\_\_\_

Phone Number: \_\_\_\_\_

Can this person have full access to the employer website? This will include employee data like salary and home address.

Yes.  No

Does this group need a specific contact for billing? Multiple billing locations and location specific billing contacts will be handled in the billing information section. **This person:**

- Will receive billing notifications. **NOTE: all billing statements will be accessed online.**

Yes, there is a specific billing contact. Provide the info below.  No

Name: \_\_\_\_\_

Email Address: \_\_\_\_\_

Date of birth (required to setup online access): \_\_\_\_\_

Phone Number: \_\_\_\_\_

**Does the group have a third party administrator (TPA)?**

Yes  No

**\*If yes, does this TPA also administer COBRA?**

Yes  No

## Employment questions

**Total number of company employees (i.e. those on your payroll):** \_\_\_\_\_

**Total number of eligible employees (those that qualify based on eligibility hours/plan provisions):** \_\_\_\_\_

**How many hours must an employee work to be eligible for benefits?**

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

Other. Indicate number of hours (between 20 and 40): \_\_\_\_\_

New Mexico contract states – for dental and vision, employees working an average of at least 20 hours per week over a 6 month period may also be eligible for insurance

**Employers in Colorado, Washington, or Florida: Is the group considered a small employer?**

Yes  No

Small employer is defined as: On average, employed 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: Average number of employees group had in prior calendar year:** \_\_\_\_\_

**Are any employees not actively at work?**

Yes, fill out the info below. Group primary contact will receive a Not Actively at Work Addendum for completion via Adobe eSign. This information will also need to be validated and provided on the signed documents.

First and Last name: \_\_\_\_\_

Reason not actively at work: \_\_\_\_\_

Last day worked: \_\_\_\_\_

Expected return date (if known): \_\_\_\_\_

No

**If you have 5-9 eligible lives, and are enrolling in Basic Life, VTL, Short-Term Disability, Long-Term Disability, or Critical Illness:** Group primary contact will receive a Field Underwriting Questionnaire for validation and signature completion via Adobe eSign.

To the best of your knowledge has any employee or dependent (if applicable) received medical treatment, consultation, care, or services for, or been diagnosed as having a back condition, cancer, heart disease, kidney disorder, liver disorder, stroke, or other serious or debilitating illness in the last 12 months?

Yes  No

Are there any employees who are currently not actively at work due to injury or illness or who have been out of work due to injury or illness for at least 5 consecutive working days in the last 12 months?

Yes  No

**Are any covered employees residing outside the United States?**  Yes, provide the info below  No

**\*If yes, provide the following (if multiple employees, provide info below on a separate sheet):**

Name: \_\_\_\_\_ Salary: \_\_\_\_\_

Employee location: \_\_\_\_\_ Expected return date: \_\_\_\_\_

Class of employee: \_\_\_\_\_

## Legal questions

ERISA information will default to YES for eligible groups and the Plan Administrator will be defaulted to the Group Primary Contact.

Plan's fiscal year end date (if blank, we'll default to your Policy Anniversary). This should be the last day of the month: \_\_\_\_\_  
MM/DD

**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.**  Yes, provide info below.  No

### \*If yes, how does the group want to be billed for COBRA?

Group bill policyholder. COBRA members are included on the group's monthly bill. If group has a COBRA TPA, this option must be selected.

COBRA vendor name (if applicable): \_\_\_\_\_

Direct bill COBRA individual. Principal bills the COBRA members directly and won't be included on the group's monthly bill.

NOTE: 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

## 3. Coverage Information:

### Case questions

**Will domestic partners be covered (assuming same and opposite sex)?** (State restrictions may apply)

Yes  No

**Does this company have coverage with a prior carrier?**

Yes. Complete info below and provide copy of prior carrier bill and booklet/summary  No

### \*If Yes, complete prior carrier information: Provide 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 you have a prior carrier, please complete the following:

**Did the group's prior dental insurance include orthodontia treatment?**

Yes  No

**Did your prior dental insurance include a maximum rollover feature (i.e. maximum accumulation, max rollover, max builder)?**

Yes (provide prior carrier report showing each employee and dependent maximums accumulated)  No

### VTL: If you have a prior carrier, please complete the following:

**Spouse Voluntary Term Life rates are based on:**

Spouse age (standard option)  Employee Age (allowed for uni-smoker rates)

### Critical Illness: If you have a prior carrier, please complete the following:

**Spouse Critical Illness rates are based on:**

Spouse age (standard option)  Employee Age (allowed for uni-smoker rates)

**Will retirees be eligible for coverage (\*restrictions apply)?** (Life, Dental, Vision)

Yes  No

**If yes, please choose one option:**  Current Retirees  Future Retirees  Both Current and Future

**Select coverage(s) retirees are eligible for:**  Life  Dental  Vision

**Definition of retirees (optional):** \_\_\_\_\_

## Coverage questions

### Are you utilizing an Electronic Data Interchange (EDI / eFile Vendor)?

- No  Yes: Outside Party Service Agreement required

#### 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.
- **This section excludes EASE and Employee Navigator**

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 the group like ID Cards sent? Groups with less than 10 eligible employees will automatically go to the member home address.**

- Employer – Mailing Address (must be 10+ eligible lives)  
 Member – Home Address (please note that this option may take longer to receive)  
 Employer – Physical Address from Employer Application (must be 10+ eligible lives)

**Dental and Vision: What company name should appear on ID cards for subsidiary/affiliate companies?**

- Not applicable  
 Legal name of parent company for all ID cards  
 Name of company employee works for (enrollment must indicate employer name for each employee)

**What is the group's definition of compensation for benefits based on salary?** (Group Term Life, Voluntary Term Life, Short-Term Disability, Long-Term Disability) Ensure the employee enrollment includes full earnings based on option selected below.

- Base wage (excludes bonus, commissions, overtime)  
 Base wage with bonus \*  
 Base wage with commission \*  
 Base wage with bonus and commission \*  
 W2 \*  
 Not applicable

**\*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?

- Yes: the employer will enroll **online through eService** after the case is installed.  
 No

## Job class setup

**Are there any employee groups that need to be excluded from benefits?**

- Yes: Excluded group name: \_\_\_\_\_  
 No

**If you are a school group, complete section 7.**

## Waiting periods

### When should employees be enrolled for coverage?

- The first day of the month coinciding with or following final day of the eligibility waiting period. *Example: If there's a 0 day waiting period, a member hired 1/1 would be effective on 1/1*
- The day immediately following the final day of the eligibility waiting period
- First day of the insurance month following the final day of the waiting period (by removing coinciding language, employees effective on the first of the month will wait an additional month to be eligible for coverage) . *Example: If there's a 0 day waiting period, a member hired 1/1 would wait until 2/1 to be effective.*

### 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 the 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.*

- Yes: provide the info below
- No

#### **\*If Yes, complete this section:**

**What is the length of your company Orientation Period? (up to a maximum of 30 days 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.

### How will the waiting periods be set up for this group?

- Case level – One waiting period for all employees. Provide the following info:

Who will the waiting period apply to?

- All employees (time credited towards prior carrier waiting period will be applied)
- Only to employees hired AFTER the effective date.

How long will the waiting period be?

- Days \_\_\_\_\_  Months \_\_\_\_\_  
(Indicate # of days) (Indicate # of months)

- Job class level – waiting periods are determined per job class. Complete details in [Section 6](#)
- Coverage level – waiting periods are determined by coverage type. Complete details in [Section 6](#)
- Job class AND Coverage level – waiting periods are determined per coverage for each job class. Complete details in [Section 6](#)
- This group does not have a waiting period

## Employer Contributions

Enter the contribution percentage the **employer** pays for the employee/dependents.

|                                 |  |                                   |                   |
|---------------------------------|--|-----------------------------------|-------------------|
| <b>Dental:</b>                  | Employee: _____ %  | Dependent: _____ %                | Retiree*: _____ % |
| <b>Vision:</b>                  | Employee: _____ %  | Dependent: _____ %                | Retiree*: _____ % |
| <b>Basic Life/AD&amp;D:</b>     | Employee: _____ %  | Dependent: _____ %                | Retiree*: _____ % |
| <b>Voluntary Life/AD&amp;D:</b> | Employee: _____ %  | Dependent: _____ %                |                   |
| <b>Critical Illness:</b>        | Employee: _____ %  | Dependent: _____ %                |                   |
| <b>Accident Coverage:</b>       | Employee: _____ %  | Dependent: _____ %                |                   |
| <b>Hospital Indemnity:</b>      | Employee: _____ %  | Dependent: _____ %                |                   |
| <b>Short Term Disability:</b>   | Employee: _____ %  | Bonus Up <input type="checkbox"/> |                   |
|                                 | Employee contributions: Pre Tax <input type="checkbox"/> Post Tax <input type="checkbox"/> |                                   |                   |
| <b>Long Term Disability:</b>    | Employee: _____ %  | Bonus Up <input type="checkbox"/> |                   |
|                                 | Employee contributions: Pre Tax <input type="checkbox"/> Post Tax <input type="checkbox"/> |                                   |                   |

## 4. Billing Information:

### What type of billing will this group use?

- Standard Billing: Principal will generate a monthly bill showing all employees for the group. This monthly statement will be accessed online.
- Self-Accounting: the group generates their own bill (requires prior approval and completed agreement)

#### For Standard billing: Complete the following:

#### How many bills does the group need?

- Single bill – only one bill needs to be produced.
- Multiple bills – the group needs separate bills for units, departments, or locations. Enrollment forms/census must show billing unit name for each employee

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

- Group primary contact listed above in section 2
- Other billing contacts as listed below

#### Additional Billing / Location Information

Billing Unit Name: \_\_\_\_\_

Contact Name: \_\_\_\_\_

Email Address: \_\_\_\_\_

Date of birth (required to setup online access): \_\_\_\_\_

Phone Number: \_\_\_\_\_

#### Division Billing?

- No
  - Yes: Employee Enrollment forms/census must show division name for each employee
- If yes, include billing division names: \_\_\_\_\_

#### Additional Billing / Location Information (continued)

Billing Unit Name: \_\_\_\_\_

Contact Name: \_\_\_\_\_

Email Address: \_\_\_\_\_

Date of birth (required to setup online access): \_\_\_\_\_

Phone Number: \_\_\_\_\_

#### Division Billing?

- No
  - Yes: Employee Enrollment forms/census must show division name for each employee
- If yes, include billing division names: \_\_\_\_\_

#### For Single Bill: Does the group need their bill broken down by unit, department, or location within the single bill produced (division billing)?

- No
  - Yes: Employee Enrollment forms/census must show division name for each employee
- If yes, include billing division names: \_\_\_\_\_

## 5. Additional Information:

Are there additional details we should know? If so, please provide:

\_\_\_\_\_

\_\_\_\_\_

Thank you for providing us with these details.

## 6. Waiting periods by Job Class and/or Coverage:

Job Class Name: \_\_\_\_\_ Coverages: \_\_\_\_\_

**Job Class / Coverage Waiting Period:** (Skip this section if waiting period is the same for all employees)

Who will the waiting period apply to?

- All employees (time credited towards prior carrier waiting period will be applied)
- Only to employees hired AFTER the effective date

How long will the waiting period be?

- None       Days \_\_\_\_\_ (Indicate # of days)       Months \_\_\_\_\_ (Indicate # of months)

**Job Class Name:** \_\_\_\_\_ **Coverages:** \_\_\_\_\_

**Job Class / Coverage Waiting Period:** (Skip this section if waiting period is the same for all employees)

Who will the waiting period apply to?

- All employees (time credited towards prior carrier waiting period will be applied)  
 Only to employees hired AFTER the effective date

How long will the waiting period be?

- None       Days \_\_\_\_\_ (Indicate # of days)       Months \_\_\_\_\_ (Indicate # of months)

[Return to Form](#)

## 7. School Group Questions (only complete if group is a school)

School groups have unique characteristics that need to be considered when issuing insurance policies and booklets. To help ensure our policies and booklets match your administrative practices and understanding, we need to validate the items below.

Check the statements below that apply to the teachers and other employees employed by the school. If multiple classes, provide info below on a separate sheet if necessary to clarify differences between teachers, administrators, non-exempt employees, etc.

**Employee Class** \_\_\_\_\_

*Employee classes often differ from employee member groups which are usually defined by product benefit differences. Classes are often defined by different pay schedules, paid by contract, different working schedules, and benefit coverage period differences.*

**Are employees paid according to a contract?**

- Yes:  
 No

**For VTL, Basic Life, Critical Illness, Accident, and/or Hospital Indemnity coverage, continued:**

**Does the policyholder plan to allow coverage during the summer break when the employees are not working?**

- Yes  
 No: if no to this question, AND employee is not paid according to a contract, coverage should not be allowed for any employees that are not teachers if they are not on contract and do not work during the summer break.

**For Short Term and/or Long Term Disability**

**Are employees paid according to a contract?**

- Yes  
 No

**The employees work:**

- 12 months of the year  
 Only during the academic school year, which is \_\_\_\_\_ months OR \_\_\_\_\_ days. Note that if this option is selected and employees are NOT paid according to a contract, the employees may be considered seasonal, more review will be needed.

**If employees only work during the academic school year, and ARE paid to contract, does the policyholder plan to allow coverage during the summer break when the employees are not working? (standard = Y)**

- Yes.
- If academic school year is days then school uses 1 divided by working days to deduct pay during the academic year
  - If academic school year is months then school uses Standard paycheck to deduct pay during the academic year
- No



## 8. Agent and Agency Information (for your broker to complete)

### General Agent Information (if applicable):

Company Name \_\_\_\_\_

### Signing Agent Information:

Name \_\_\_\_\_ Last 4 Digits of SSN or NPN: \_\_\_\_\_

% 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 or NPN: \_\_\_\_\_

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