Principal Life Insurance Company

Mailing Address:
Des Moines, IA
50392-0002

Employer Application for Group Insurance - CA

PLEASE USE BLACK INK

To avoid processing delays, please make sure you answer all questions completely and accurately. For an amendment to an existing account, if no changes are noted in the sections below, current elections will remain in effect.

California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.

This form is for: ☐ new case ☐ amendment Account number _____

Requested effective date: _____

Employer Information (if this is an amendment, only complete information that is changing)

Legal name of company	Federal tax ID number

DBA name (if applicable)

Physical street address	City	State	ZIP code

Affiliate/Subsidiary Information (if this is an amendment, only complete information that is changing)

Are employees of any associated business organizations (e.g. parent-subsidiary, brother-sister relationships, affiliated groups, etc.) to be covered? ☐ yes ☐ no If yes, 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.			
2.			

Request for Benefits (if adding new coverage(s) to an existing account, provide new proposal number)

By signing this Application form, you are confirming that you agree with all the benefit plan provisions that you are applying for as outlined in your proposal # _____. Do you agree? ☐ yes ☐ no

Employee Eligibility (if this is an amendment, only complete information that is changing)

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

☐ other (select between 20 and 40 hours): _____

Do you have employees or their dependents residing or working outside the United States and requesting coverage?

☐ yes ☐ no If yes, please include a separate sheet including their name(s), dates of birth, salary and class of employee, where they are located and how long they will be located there for work.

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 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, you must indicate a Named Fiduciary for this plan. Principal Life may not be designated as Named Fiduciary.

- 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 organization within the meaning of the Internal Revenue Code; or is a government agency; 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. The employer acknowledges and understands that if this application is approved, the group policy will determine all rights and benefits.
- The preexisting condition restrictions for critical illness and long term disability insurance have been explained to and understood by the employer. Actively at work and period of limited activity for life, disability and critical illness coverage 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.
- The employer understands that the insurance policy and certificates of coverage may, at the discretion of Principal Life, be provided to the employer in paper or electronic format. The employer agrees to promptly distribute the certificates of coverage to insured employees at the beginning of their coverage under the group policy and to redistribute them from time to time thereafter as reasonably required by Principal Life.
- 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.
- As a result of this sale and any subsequent renewal, your broker and marketing organization, if any, may receive commissions, administrative service fees, other compensation including non-cash compensation, and bonuses based on factors such as, volume of new sales, member and case counts, total premium volume, maintaining a certain percentage of business with Principal Life, selling a certain mix of products, and/or the profitability of the business. The cost of this compensation may be directly or indirectly reflected in the premium or fee for the product(s) you have applied for on this application form. This compensation is in addition to any compensation the broker may receive from you. Contact us at 1-800-388-4793 for further details on your case. We have placed a more detailed description of our compensation programs on www.principal.com/group/compensation.
- 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.
- The employer understands their rights and responsibilities if electing self accounting status.

Any false statement made on this form will not bar the right to recovery under the group policy(ies) unless such false statement was made with actual intent to deceive or unless it materially affected either the acceptance of the risk or the hazard assumed by Principal Life.

Employer (company name)

GA : B&P

Signed by (must be an officer)	Officer's title	Date signed
X		

Printed officer name

Signature of licensed resident agent(s) (individual/firm)	Agent's license number	Date signed
X		

Licensed resident agent(s) printed name(s)

Signature of soliciting agent(s) (If more than one, all must sign.)	Date signed
X	

Soliciting agent(s) printed name(s)

For Principal Life Use Only

Principal®

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Des Moines, IA 50392-0002

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Addendum to Employer Application for Group Insurance

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To avoid processing delays, please make sure you answer all questions completely and accurately.

This form is for: ☐ new case ☐ amendment to add Life/Disability/Critical Illness Account number _____

Life/Disability/Critical Illness

If requesting life, disability or critical illness insurance, are there any employees not Actively at Work? ☐ yes ☐ no

If yes, please list employees not Actively at Work, reason not Actively at Work, their last day worked and expected return to work date.

Signatures

Employer (company name)

Signed by (must be an officer)	Officer's title	Date signed
X		

Printed officer name

Print