

SERFF Tracking Number: PRLF-126150190 State: Arkansas
Filing Company: Principal Life Insurance Company State Tracking Number: 42532
Company Tracking Number:
TOI: L04G Group Life - Term Sub-TOI: L04G.500 Other
Product Name: Single Case Filing - VTL - AR
Project Name/Number: /

Filing at a Glance

Company: Principal Life Insurance Company

Product Name: Single Case Filing - VTL - AR

TOI: L04G Group Life - Term

Sub-TOI: L04G.500 Other

Filing Type: Form

SERFF Tr Num: PRLF-126150190 State: Arkansas

SERFF Status: Closed-Approved-
Closed State Tr Num: 42532

Co Tr Num:

State Status: Approved-Closed

Reviewer(s): Linda Bird

Authors: Bonnie Blue, Jan Majerus

Disposition Date: 06/03/2009

Date Submitted: 05/27/2009

Disposition Status: Approved-
Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name:

Status of Filing in Domicile: Not Filed

Project Number:

Date Approved in Domicile:

Requested Filing Mode: Review & Approval

Domicile Status Comments:

Explanation for Combination/Other:

Market Type: Group

Submission Type: New Submission

Group Market Size: Large

Overall Rate Impact:

Group Market Type: Employer

Filing Status Changed: 06/03/2009

Explanation for Other Group Market Type:

State Status Changed: 06/03/2009

Deemer Date:

Created By: Jan Majerus

Submitted By: Jan Majerus

Corresponding Filing Tracking Number:

Filing Description:

Enclosed for your review and approval are copies of the above listed form, which is being submitted for approval on a single case basis.

A large insured group policyholder located in Arkansas has requested changing their grace period to 60 days. The changes are italicized on the attached policy and booklet certificate insert pages for your ease in reviewing.

If approved, these pages will be used for this one case only, with our Group Voluntary Term Life Insurance Policy forms series GC 6000 (VTL), et al, (most recently filed and approved March 26, 2002, with various subsequent filing and approval dates for changes). The entire Group Voluntary Term Life Insurance policy forms for this group were previously

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filed and approved on June 5, 2008.

Enrollment form number GP 56002 is specific to this policyholder is also included. Please note this enrollment form was included in the Group Term Life filing for this policyholder, SERFF Tracking Number PRLF – 125595388 and was approved on June 9, 2008.

No part of this filing contains any unusual or controversial items from normal industry standards.

Thank you for your consideration of this submission. All required certification forms are enclosed.

If you have any questions on any of the attached materials, please feel free to contact me by fax, e-mail or at the toll-free number shown below.

Company and Contact

Filing Contact Information

Jan Majerus, State/Federal Compliance Analyst Majerus.Jan@principal.com
 711 High Street 800-986-3343 [Phone] 83337 [Ext]
 K-005-E81 515-246-2491 [FAX]
 Des Moines, IA 50392-0002

Filing Company Information

Principal Life Insurance Company CoCode: 61271 State of Domicile: Iowa
 711 High Street Group Code: 332 Company Type: Life & Health
 Des Moines, IA 50392-0002 Group Name: State ID Number:
 (800) 986-3343 ext. [Phone] FEIN Number: 42-0127290

Filing Fees

Fee Required? Yes
 Fee Amount: \$50.00
 Retaliatory? No
 Fee Explanation:
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Principal Life Insurance Company	\$50.00	05/27/2009	28110830

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	06/03/2009	06/03/2009

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Disposition

Disposition Date: 06/03/2009

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		Yes
Form	PART II - POLICY ADMINISTRATION		Yes
	Part B - Premiums		

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Form Schedule

Lead Form Number: GC 6004 (VTL) DIL-1

Schedule Item Status	Form Number	Form Type Form Name	Action	Action Specific Data	Readability	Attachment
	GC 6004 (VTL) DIL-1	Policy/Contract/Fraternity Certificate: Amendment, Insert Page, Endorsement or Rider	Revised	Replaced Form #: gc 6004 (vtl) dil Previous Filing #: PRLF-125595392		GC 6004 _VTL_ DIL-1.pdf

PART II - POLICY ADMINISTRATION

Section B - Premiums

Article 1 - Payment Responsibility; Due Dates; Grace Period

The Policyholder is responsible for collection and payment of all premium due while this Group Policy is in force. Payments must be sent to the home office of The Principal in Des Moines, Iowa.

The first premium is due on the Date of Issue of this Group Policy. Each premium thereafter will be due on the first of each Insurance Month. Except for the first premium, a Grace Period of **60** days will be allowed for payment of premium. "Grace Period" means the first **60**-day period following a premium due date. The Group Policy will remain in force until the end of the Grace Period, unless the Group Policy has been terminated by notice as described in this PART II, Section C. The Policyholder will be liable for payment of the premium for the time this Group Policy remains in force during the Grace Period.

Article 2 - Premium Rates

The premium rate(s) for each Participant insured for Life Insurance will be:

a. Participant Life Insurance

(Rate for each \$1,000 of insurance in force)

Smoking Status

(Participant Age)	Unismoker
29 and Under	\$0.045
30-34	\$0.055
35-39	\$0.070
40-44	\$0.070
45-49	\$0.120
50-54	\$0.200
55-59	\$0.400
60-64	\$0.585
65-69	\$1.145
70 and over	\$1.855

b. Dependent Life Insurance - \$10,000

\$2.00 for each Participant insured for Dependent Life Insurance for the Participant's Dependent Child.

PART II - POLICY ADMINISTRATION

For the Participant's Dependent spouse:

(Rate for each \$1,000 of
insurance in force)

(Person's Age)	Smoking Status	
	Unismoker	
29 and Under	\$0.045	
30-34	\$0.055	
35-39	\$0.070	
40-44	\$0.070	
45-49	\$0.120	
50-54	\$0.200	
55-59	\$0.400	
60-64	\$0.585	
65-69	\$1.145	
70 and over	\$1.855	

Article 3 - Premium Rate Changes

The Principal may change a premium rate:

- a. on any premium due date, if the initial premium rate has then been in force 3 year(s) or more and if Written notice is given to the Policyholder at least 31 days before the date of change; or
- b. on any date the definition of Participant or Dependent is changed; and
- c. on any date the Policyholder's business, as specified on the Policyholder application, is changed; and
- d. on any date that a schedule of insurance or class of insured Participants is changed; and
- e. on any date the premium contribution required of Participants is changed; and
- f. on any June 1st, if the age for then insured Participants has changed since the last Policy Anniversary.

If the Policyholder has other group insurance with The Principal, and if life insurance is initially added on a date other than the Policy Anniversary and it is more than six months before the next Policy Anniversary, The Principal reserves the right to change the premium rate on the next Policy Anniversary. Written notice will be given to the Policyholder at least 31 days before the date of change.

PART II - POLICY ADMINISTRATION

If the Policyholder agrees to participate in the electronic services program of The Principal and, at a later date elects to withdraw from participation, such withdrawal may result in certain administrative fees being charged to the Policyholder.

Article 4 - Premium Amount

The amount of premium to be paid on each due date will be determined in these ways:

- a. Participant Life Insurance
The total volume of insurance in force for Participants in each age bracket will be divided by 1,000. Each result will then be multiplied by the premium rate then in effect for that age bracket.
- b. Dependent Life Insurance
The number of Participants insured for Dependent Life Insurance for the Participant's Dependent Child will be multiplied by the premium rate then in effect.

The total volume of insurance in force for the Participant's Dependent spouse in each age bracket will be divided by 1,000. Each result will then be multiplied by the premium rate then in effect for that age bracket.

To ensure accurate premium calculations, the Policyholder is responsible for reporting to The Principal, the following information during the stated time periods:

- a. Participants who are eligible to become insured are to be reported during the month prior to or during the month that insurance becomes effective.
- b. Participants whose insurance has terminated are to be reported within a month of the date insurance terminated.
- c. Changes in Participant insurance class are to be reported during the month of or prior to the Policy Anniversary.

If a Participant is added or a present Participant's insurance is increased or terminated on other than the first of an Insurance Month, premium for that Participant will be adjusted and applied as if the change were to take place on the first of the next following Insurance Month.

Article 5 - Contributions from Participants

Participants are required to contribute all of the premium for their insurance under this Group Policy.

Participants are required to contribute all of the premium for their Dependent's insurance under this Group Policy.

PART II - POLICY ADMINISTRATION

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Supporting Document Schedules

	Item Status:	Status Date:
Satisfied - Item: Flesch Certification		
Comments:		
Attachment: Readability Cert.pdf		

	Item Status:	Status Date:
Satisfied - Item: Application		
Comments: this form was previously included in filing PRLF-125595392 approved on 6-5-08.		
Attachment: GP56002.pdf		

**STATE OF ARKANSAS
INSURANCE DEPARTMENT**

CERTIFICATION OF READABILITY

I, Mark L. Hill, an Officer of Principal Life Insurance Company hereby certify that the attached form(s) has (have) achieved a Flesch Reading Ease Score of:

Form No.	Form Name	Flesch Score
GC 6004 (VTL) DIL-1	Group Voluntary Term Life Insurance Policy Form	58.3

and complies with the requirements of Ark. Stat. Ann. Sections 66-3251 through 66-3258, cited as the Life and Disability Insurance Policy Language Simplification Act.

PRINCIPAL LIFE INSURANCE COMPANY



Mark L. Hill, Director
Group Life and Health Compliance

May 27, 2009 _____
Date



Mailing Address: Des Moines, IA 50392-0002

Principal Life Insurance Company Health Statement for Self Administered Plans

Account Number / Unit Number H35922

Employer to Complete This Section: After completing make a copy of Page 1 for your records before you give the form to your employee.

Employer name Dillard's, Inc.

Direct all employer's correspondence regarding this statement to: Name Benefits Department

Address (street) 1600 Cantrell Road

City State ZIP code Phone Little Rock AR 72201 (501) 376-5933

Employee's name AIN number Date of hire Annual salary \$

Effective date as per contractual provisions open enrollment - effective date June 1st

This statement is: (place a "(v)" in each box that applies) for employee add new coverages increase in current coverages for dependent(s) late

Please check the coverages (and indicate the new amount or increase in amount) being applied for at this time. See your benefit plan/contract for proof of good health rules that apply to your plan.

Table with 3 columns: Coverage type, Current amount, Requested amount. Rows include basic life, voluntary term life (employee/spouse/child), short term disability, and long term disability.

Employee to Complete This Section

120-0

Your name (last, first, middle initial) _____ Home phone number _____

Home address (street) _____

City _____ State _____ ZIP code _____

Date of birth _____ Are you married? male female yes no Date of marriage _____

Name of spouse _____ Spouse's date of birth _____

This statement is for:

myself		my spouse		my children			
Name of each dependent child applying for coverage (last, first, middle initial)	Sex	Date of birth	Full-time student	Foster/step child*	Disabled or handicapped* child		
1.							
2.							
3.							
4.							

Are additional children listed on separate page? yes Please sign and date all pages.

* Foster and stepchildren, eligibility is determined by employer. For disabled, handicapped children, complete the appropriate form.

Health Information for All Coverages Being Applied for

Answer only for those individuals requesting coverage. To prevent delays answer each question and give full details to "yes" answers. All statements and descriptions on this form shall be deemed to be representations and not warranties.

Employee's height _____ ft. _____ in. weight _____ lbs. Spouse's height _____ ft. _____ in. weight _____ lbs.

1.	yes	no	Is any person on whom coverage is requested currently using tobacco products, including cigarette, pipe, cigar or chewing tobacco? If so, how long? _____ Which applicant(s)? _____																				
2.	yes	no	Is any person on whom coverage is requested currently receiving medical treatment, taking medication, or pregnant?																				
3.	yes	no	In the past 5 years , has any person on whom coverage is requested had surgery, been hospitalized or consulted with a doctor, had blood or other diagnostic tests (other than for HIV antibody), or been advised to receive medical treatment?																				
4.	yes	no	In the past 5 years , has any person on whom coverage is requested been diagnosed with or received treatment for any of the following (check all that apply)? <table border="0" style="width: 100%;"> <tr> <td>cancer</td> <td>liver disorder</td> <td>bone disorder</td> <td>mental disorder</td> </tr> <tr> <td>tumors</td> <td>kidney disorder</td> <td>joint disorder</td> <td>nervous disorder</td> </tr> <tr> <td>heart condition</td> <td>muscle disorder</td> <td>urinary disorder</td> <td>diabetes</td> </tr> <tr> <td>high blood pressure</td> <td>multiple sclerosis/ neurological disorder</td> <td>respiratory disorder</td> <td>hepatitis</td> </tr> <tr> <td>stroke</td> <td></td> <td></td> <td></td> </tr> </table>	cancer	liver disorder	bone disorder	mental disorder	tumors	kidney disorder	joint disorder	nervous disorder	heart condition	muscle disorder	urinary disorder	diabetes	high blood pressure	multiple sclerosis/ neurological disorder	respiratory disorder	hepatitis	stroke			
cancer	liver disorder	bone disorder	mental disorder																				
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heart condition	muscle disorder	urinary disorder	diabetes																				
high blood pressure	multiple sclerosis/ neurological disorder	respiratory disorder	hepatitis																				
stroke																							
5.	yes	no	In the past 10 years , has any person on whom coverage is requested been treated for, diagnosed as having or tested positive for Acquired Immune Deficiency Syndrome (AIDS), AIDS-Related Complex (ARC), or any other immune disorder?																				

Health Information for All Coverages Being Applied for (continued)

120-0

Provide details for all "yes" answers. If more space is needed, attach a separate page giving full details. Sign and date all pages.

Name	Date diagnosed/treated	Duration of illness or condition
Diagnosis of illness or condition	Type of treatment/names of all medications	
Any current symptoms or problems		
Names and addresses of doctors, hospitals or other providers		

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Name	Date diagnosed/treated	Duration of illness or condition
Diagnosis of illness or condition	Type of treatment/names of all medications	
Any current symptoms or problems		
Names and addresses of doctors, hospitals or other providers		

Authorization, Acknowledgment, and Signatures

- I represent information, statements, and answers on this form, and any attachments, are complete and true to the best of my knowledge. They are a part of this request for coverage under the group policies. I agree Principal Life Insurance Company is not liable for anyone's claim which happens or begins before the effective date of coverage or approval of any life and disability coverage.
- I have read, or had read to me, the questions and responses and realize any false statements, omissions or material misrepresentation regarding age or health information could cause life and disability coverages, if issued, to be cancelled as never effective.
- 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.
- I understand all policy provisions for medical coverage will apply. If approved for life and disability coverages, all policy provisions will apply including, but not limited to, preexisting conditions restriction, the Actively at Work and Period of Limited Activity provisions.
- I understand an agent cannot change or waive any rates, benefits, or provisions of any policy, if issued, without the written approval of an officer of Principal Life.
- For life and disability coverages, I authorize any doctor, health care provider, hospital, clinic or medically related facility, insurance company, consumer reporting agency or employer, that has any personal information, including physical, mental, drug or alcohol use history, regarding me or any dependent, to give to Principal Life, its agents and employees performing business transactions, any such data.

- I authorize Principal Life to release any such data as required by law. When signed in connection with any application for, reinstatement of, or request for change in benefits, this form shall be valid for two years after the date shown below. I understand I may revoke this authorization for information not then obtained. A photocopy of this form shall be as valid as the original.
- I understand the data obtained by use of this authorization will be used by Principal Life for claims administration and to determine eligibility for life and disability coverage. This information will not be used for any purposes prohibited by law.

Employee's signature	Date signed
Spouse's signature*	Date signed

*Spouse signature only required if Voluntary Term Life coverage is elected.

Notice of Information Practices for Life and Disability Coverages

In order to properly underwrite and consider your request for coverage, we must collect information to determine if you (and your dependents if also requesting dependent coverage) qualify for insurance with Principal Life. We will do this by having you complete this Health Statement. In addition, we may contact sources besides yourself for personal data about any proposed insured, including (a) spouse, (b) employer, (c) medical professionals or institutions, and (d) insurance companies to which you may have applied for insurance in the past. The personal data may include age, medical history, job, income, habits and other personal characteristic information. We may also ask that medical exams or other tests be completed.

We will keep your data confidential. Only employees performing business transactions regarding your coverage will see your data. In certain circumstances, we may provide data to (a) government agencies, (b) attending physicians, (c) insurance organizations without identification, and (d) the employer, if applicable, for the purpose of reporting claims experience or conducting audits.

You or your dependents, if applicable, have certain rights in connection with this request for coverage. Those rights are:

1. to find out what personal information is contained in Principal Life files (medical information may be disclosed only to your attending physician).
2. to correct or amend information in Principal Life files.

Upon written request, Principal Life will furnish to you (or your dependent) information concerning:

1. the nature and scope of personal data in our records;
2. the types of disclosures which may be made; and
3. rights of access to the information collected and how such information may be corrected or amended.

We will respond to such written request within 30 days from the date of receipt.

For further information about your file or rights, you may contact: Group Operations, Medical Underwriting, Principal Life Insurance Company, Des Moines, IA 50392-0432.

Instructions for Employee

After this form is completed and signed, send original to Principal Life Insurance Company, Des Moines, IA 50392-0002, and make a copy for your records.