

SERFF Tracking Number: PRLF-126245114 State: Arkansas  
 Filing Company: Principal Life Insurance Company State Tracking Number: 43446  
 Company Tracking Number:  
 TOI: H11G Group Health - Disability Income Sub-TOI: H11G.003 Long Term  
 Product Name: Dillards - LTD - Revisions  
 Project Name/Number: /

## Filing at a Glance

Company: Principal Life Insurance Company

Product Name: Dillards - LTD - Revisions

TOI: H11G Group Health - Disability Income

Sub-TOI: H11G.003 Long Term

Filing Type: Form

SERFF Tr Num: PRLF-126245114 State: Arkansas

SERFF Status: Closed-Approved-  
Closed State Tr Num: 43446

Co Tr Num:

State Status: Approved-Closed

Reviewer(s): Rosalind Minor

Authors: Bonnie Blue, Jan Majerus

Disposition Date: 09/23/2009

Date Submitted: 09/08/2009

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: 09/23/2009

Explanation for Other Group Market Type:

State Status Changed: 09/23/2009

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 forms, which are being submitted for approval on a single case basis.

A large insured group policyholder located in Arkansas has requested participants covered under H 35922 have a 12 month limit for Special Conditions, and a special benefit reduction schedule. The changes are red italicized on the attached policy insert page for your ease in reviewing.

If approved, this page will be used for this one case only, with our Group Long Term Disability Insurance Policy forms series GC 3000, et al, (most recently filed and approved March 14, 2002, with various subsequent filing and approval

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dates for changes). The Group Long Term Disability policy and booklet-certificate forms used for this policyholder were filed and approved on June 9, 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: \$200.00  
Retaliatory? No  
Fee Explanation: 10 forms times  
20.00 per form =  
\$200.00  
Per Company: No

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COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Principal Life Insurance Company	\$200.00	09/08/2009	30396045

SERFF Tracking Number: PRLF-126245114 State: Arkansas  
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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	09/23/2009	09/23/2009

SERFF Tracking Number: PRLF-126245114 State: Arkansas  
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Product Name: Dillard's - LTD - Revisions  
Project Name/Number: /

## Disposition

Disposition Date: 09/23/2009

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: PRLF-126245114 State: Arkansas  
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 Product Name: Dillardards - LTD - Revisions  
 Project Name/Number: /

Schedule	Schedule Item	Schedule Item Status	Public Access
<b>Supporting Document</b>	Flesch Certification	Approved-Closed	Yes
<b>Supporting Document</b>	Application	Approved-Closed	Yes
<b>Supporting Document</b>	LTD Footnotes	Approved-Closed	Yes
<b>Form</b>	TABLE OF CONTENTS	Approved-Closed	Yes
<b>Form</b>	PART IA - LONG TERM DISABILITY INSURANCE SUMMARY	Approved-Closed	Yes
<b>Form</b>	[PART IV - BENEFITS - Section E - Survivor Benefit and Accelerated Survivor Benefit	Approved-Closed	Yes
<b>Form</b>	PART IV -BENEFITS - Section M - Benefit Payment Period and Recurring Disability	Approved-Closed	Yes
<b>Form</b>	PART IV - BENEFITS - Section N - Treatment of Alcohol, Drug or Chemical Abuse, Dependency, or Addiction, a Mental Health Condition, or a Special Condition	Approved-Closed	Yes
<b>Form</b>	TABLE OF CONTENTS	Approved-Closed	Yes
<b>Form</b>	LONG TERM DISABILITY INSURANCE SUMMARY	Approved-Closed	Yes
<b>Form</b>	DESCRIPTION OF BENEFITS - Survivor Benefit and Accelerated Survivor Benefit	Approved-Closed	Yes
<b>Form</b>	DESCRIPTION OF BENEFITS - Benefit Payment Period and Recurring Disability	Approved-Closed	Yes
<b>Form</b>	DESCRIPTION OF BENEFITS - Treatment of Alcohol, Drug or Chemical Abuse, Dependency, or Addiction, a Mental Health Condition, or a Special Condition	Approved-Closed	Yes

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 Project Name/Number: /

## Form Schedule

### Lead Form Number:

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 09/23/2009	GC 3001-1 DIL-1	Policy/Cont ract/Fratern al	TABLE OF CONTENTS Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Revised	Replaced Form #: GC 3001 DIL Previous Filing #: 39165		GC 3001-1 DIL-1.pdf
Approved-Closed 09/23/2009	GC 3002 IL-1	Policy/Cont ract/Fratern al	PART IA - LONG TERM DISABILITY INSURANCE Certificate: SUMMARY Amendmen t, Insert Page, Endorseme nt or Rider	Revised	Replaced Form #: GC 3002 DIL Previous Filing #: 39165		GC 3002 DIL- 1.pdf
Approved-Closed 09/23/2009	GC 3026 DIL-1	Policy/Cont ract/Fratern al	[PART IV - BENEFITS - Section E - Survivor Benefit Certificate: and Accelerated Amendmen t, Insert Page, Endorseme nt or Rider	Revised	Replaced Form #: GC 3026 DIL Previous Filing #: 39165		GC 3026 DIL- 1.pdf
Approved-Closed 09/23/2009	GC 3042 DIL-1	Policy/Cont ract/Fratern al	PART IV -BENEFITS - Section M - Benefit Payment Period and Certificate: Recurring Disability	Revised	Replaced Form #: GC 3042 DIL Previous Filing #: 39165		GC 3042 DIL- 1.pdf

<i>SERFF Tracking Number:</i>	<i>PRLF-126245114</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Principal Life Insurance Company</i>	<i>State Tracking Number:</i>	<i>43446</i>
<i>Company Tracking Number:</i>			
<i>TOI:</i>	<i>H11G Group Health - Disability Income</i>	<i>Sub-TOI:</i>	<i>H11G.003 Long Term</i>
<i>Product Name:</i>	<i>Dillard's - LTD - Revisions</i>		
<i>Project Name/Number:</i>	<i>/</i>		
	Amendmen t, Insert Page, Endorseme nt or Rider		
Approved- GC 3044 Closed DIL-1 09/23/2009	Policy/Cont PART IV - ract/Fratern BENEFITS - Section al N - Treatment of Certificate: Alcohol, Drug or Amendmen Chemical Abuse, t, Insert Dependency, or Page, Addiction, a Mental Endorseme Health Condition, or nt or Rider a Special Condition	Revised	Replaced Form #: GC 3044 DIL Previous Filing #: 39165
			GC 3044 DIL- 1.pdf
Approved- GH 801 Closed DIL-1 09/23/2009	Certificate TABLE OF Amendmen CONTENTS t, Insert Page, Endorseme nt or Rider	Revised	Replaced Form #: GH 801 DIL Previous Filing #: 39165
			GH 801 DIL- 1.pdf
Approved- GH 802 Closed DIL-1 09/23/2009	Certificate LONG TERM Amendmen DISABILITY t, Insert INSURANCE Page, SUMMARY Endorseme nt or Rider	Revised	Replaced Form #: GH 802 DIL-1 Previous Filing #: 39165
			GH 802 DIL- 1.pdf
Approved- GH 811 Closed DIL-1 09/23/2009	Certificate DESCRIPTION OF Amendmen BENEFITS - Survivor t, Insert Benefit and Page, Accelrerated Survivor Endorseme Benefit nt or Rider	Revised	Replaced Form #: GH 811 DIL Previous Filing #: 39165
			GH 811 DIL- 1.pdf
Approved- GH 819 Closed DIL-1 09/23/2009	Certificate DESCRIPTION OF Amendmen BENEFITS - Benefit t, Insert Payment Period and Page, Recurring Disability Endorseme nt or Rider	Revised	Replaced Form #: GH 819 DIL Previous Filing #: 39165
			GH 819 DIL- 1.pdf

SERFF Tracking Number: PRLF-126245114 State: Arkansas  
 Filing Company: Principal Life Insurance Company State Tracking Number: 43446  
 Company Tracking Number:  
 TOI: H11G Group Health - Disability Income Sub-TOI: H11G.003 Long Term  
 Product Name: Dillard's - LTD - Revisions

Project Name/Number: /  
 Approved- GH 820 Certificate DESCRIPTION OF Revised Replaced Form #: GH 820 DIL-  
 Closed DIL-1 Amendmen BENEFITS - GH 820 DIL 1.pdf  
 09/23/2009 t, Insert Treatment of Alcohol, Previous Filing #: 39165  
 Page, Drug or Chemical  
 Endorseme Abuse, Dependency,  
 nt or Rider or Addiction, a  
 Mental Health  
 Condition, or a  
 Special Condition

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**PART IA - LONG TERM DISABILITY INSURANCE SUMMARY**

**H35922**

Participant Contribution	Participants are required to contribute a part of the premium for their insurance under this Group Policy																				
Elimination Period	The greater of salary continuance or [90 days]																				
Own Occupation Period	[two] years																				
Primary Monthly Benefit	[60%] of the Participant's Predisability Earnings.																				
Maximum Monthly Benefit	[\$6,000]																				
Minimum Monthly Benefit	the greater of [10%] of the Participant's Primary Monthly Benefit or [\$100]																				
Maximum Benefit Payment Period	<table border="0"> <tr> <td><i>Participant's Age on The Date Disability Begins</i></td> <td><i>Months of the Benefit Payment Period</i></td> </tr> <tr> <td><i>[Before age 62</i></td> <td><i>greater of 42 months or to age 65</i></td> </tr> <tr> <td><i>62</i></td> <td><i>42 months</i></td> </tr> <tr> <td><i>63</i></td> <td><i>36 months</i></td> </tr> <tr> <td><i>64</i></td> <td><i>30 months</i></td> </tr> <tr> <td><i>65</i></td> <td><i>24 months</i></td> </tr> <tr> <td><i>66</i></td> <td><i>21 months</i></td> </tr> <tr> <td><i>67</i></td> <td><i>18 months</i></td> </tr> <tr> <td><i>68</i></td> <td><i>15 months</i></td> </tr> <tr> <td><i>69 and over</i></td> <td><i>12 months]</i></td> </tr> </table>	<i>Participant's Age on The Date Disability Begins</i>	<i>Months of the Benefit Payment Period</i>	<i>[Before age 62</i>	<i>greater of 42 months or to age 65</i>	<i>62</i>	<i>42 months</i>	<i>63</i>	<i>36 months</i>	<i>64</i>	<i>30 months</i>	<i>65</i>	<i>24 months</i>	<i>66</i>	<i>21 months</i>	<i>67</i>	<i>18 months</i>	<i>68</i>	<i>15 months</i>	<i>69 and over</i>	<i>12 months]</i>
<i>Participant's Age on The Date Disability Begins</i>	<i>Months of the Benefit Payment Period</i>																				
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<i>69 and over</i>	<i>12 months]</i>																				
Rehabilitation Services and Benefits																					
Rehabilitation Services	Included																				
Predisability Intervention Services	Included																				
Rehabilitation Incentive Benefit	[5%]																				
Reasonable Accommodation Benefit	[\$2,000]																				
Other Coverage Features																					
Work Incentive Benefit	<i>[24] months</i>																				
<b>NOTE:</b>																					
No premiums are required during a Long Term Disability Benefit Payment Period.																					
Benefits may be reduced by other sources of income and disability earnings.																					
Some disabilities may not be covered or may be limited under this insurance.																					

This summary provides only highlights of this Group Policy. The entire Group Policy determines all rights, benefits, exclusions and limitations of the insurance described above.

**H35978**

Participant Contribution	Participants are required to contribute the entire premium for their insurance under this Group Policy	
Elimination Period	The greater of salary continuance or [90 days]	
Own Occupation Period	to Social Security Normal Retirement Age	
Primary Monthly Benefit	[60%] of the Participant's Predisability Earnings.	
Maximum Monthly Benefit	[\$25,000]	
Minimum Monthly Benefit	the greater of [10%] of the Participant's Primary Monthly Benefit or [\$100]	
Maximum Benefit Payment Period	Participant's Age on The Date Disability Begins _____	Months of the Benefit Payment Period _____
	Before age 65	greater of 36 months or to Social Security Normal Retirement Age
	65-67	24 months
	68-69	18 months
	70-71	15 months
	72 and over	12 months
Rehabilitation Services and Benefits		
Rehabilitation Services	Included	
Predisability Intervention Services	Included	
Rehabilitation Incentive Benefit	[10%]	
Reasonable Accommodation Benefit	[\$2,000]	
Other Coverage Features		
Work Incentive Benefit	[24] months	
Survivor Benefit	[three] times Primary Monthly Benefit	
<b>NOTE:</b>		
No premiums are required during a Long Term Disability Benefit Payment Period.		
Benefits may be reduced by other sources of income and disability earnings.		
Some disabilities may not be covered or may be limited under this insurance.		

**H35979**

Participant Contribution	Participants are required to contribute the entire premium for their insurance under this Group Policy	
Elimination Period	The greater of salary continuance or [90 days]	
Own Occupation Period	to Social Security Normal Retirement Age	
Primary Monthly Benefit	[60%] of the Participant's Predisability Earnings	
Maximum Monthly Benefit	[\$15,000]	
Minimum Monthly Benefit	the greater of [10%] of the Participant's Primary Monthly Benefit or [\$100]	
Maximum Benefit Payment Period	Participant's Age on The Date Disability Begins	Months of the Benefit Payment Period
	Before age 65	greater of 36 months or to Social Security Normal Retirement Age
	65-67	24 months
	68-69	18 months
	70-71	15 months
	72 and over	12 months
Rehabilitation Services and Benefits		
Rehabilitation Services	Included	
Predisability Intervention Services	Included	
Rehabilitation Incentive Benefit	[10%]	
Reasonable Accommodation Benefit	[\$2,000]	
Other Coverage Features		
Work Incentive Benefit	[24] months	
Survivor Benefit	[three] times Primary Monthly Benefit	
<b>NOTE:</b>		
No premiums are required during a Long Term Disability Benefit Payment Period.		
Benefits may be reduced by other sources of income and disability earnings.		
Some disabilities may not be covered or may be limited under this insurance.		

## **PART IV - BENEFITS**

### **Section E**

#### **Survivor Benefit and Accelerated Survivor Benefit**

##### **Article 1 - Survivor Benefit**

[12]

In the event a Benefit Payment Period ends because of the Participant's death, a Survivor Benefit will be payable. This Survivor Benefit will be [three] times the Participant's Primary Monthly Benefit.

The Principal will pay the Survivor Benefit to a Participant's spouse, child, parent, or estate as described in this PART IV, Section Q, Claim Procedures.

##### **Article 2 - Accelerated Survivor Benefit**

###### **a. Definition of Terminally Ill**

A Participant will be considered Terminally Ill under this article of this Group Policy if he or she is expected to die within 12 months of the date he or she requests payment of the Accelerated Survivor Benefit.

###### **b. Eligibility**

The Principal will pay the Participant an Accelerated Survivor Benefit if he or she requests such payment and meets the following requirements. The Participant must:

- (1) satisfy the Benefit Qualifications listed in this PART IV, Section A; and
- (2) provide proof that he or she is Terminally Ill by submitting to The Principal:
  - a. a statement from the Participant's Physician; and
  - b. any other medical information that The Principal believes necessary to confirm the Participant's status; and
- (3) be living on the date of payment of the Accelerated Survivor Benefit.

###### **c. Benefit**

If the Participant qualifies, The Principal will pay an Accelerated Survivor Benefit. This benefit will be equal to [three] times the Participant's Primary Monthly Benefit and will be paid to the Participant in a single lump sum. This benefit is paid in addition to the Participant's regular Benefit Payable.

## **PART IV - BENEFITS**

**d. Effect on Survivor Benefit**

If an Accelerated Survivor Benefit is paid, no Survivor Benefit will be payable.]

**PART IV - BENEFITS**

**PART IV - BENEFITS**

**Section M**

**Benefit Payment Period and Recurring Disability**

**Article 1 - Benefit Payment Period**

Benefits are payable:

- a. if Disability begins before age 62, until the later of the date 42 months after the Benefit Payment Period begins, or the date the Member attains age 65; or
- [16]* b. if Disability begins at or after age 65, *[until* the later of the date of Social Security Normal Retirement Age], or *[until]* the date of completion of the number of months shown below after the Benefit Payment Period begins.

<u>Participant 's Age on the Date Disability Begins</u>	<u>Months of the Benefit Payment Period (Beginning with the date the Benefit Payment Period begins)</u>
<i>[65-67</i>	24
68-69	18
70-71	15
72 and over	<i>12]</i>
<i>[62</i>	42
63	36
64	30
65	24
66	21
67	18
68	15
69 and over	<i>12]</i>

However, in no event, will benefits continue beyond:

- a. the date of the Participant's death; or
- b. the date Disability ends, unless a Recurring Disability exists as explained in this section; or
- c. the date the Participant fails to provide any required proof of Disability; or

**PART IV - BENEFITS**

- d. the date the Participant fails to submit to any required medical examination or evaluation as provided in this PART IV, Section Q, Article 13; or
- e. the date the Participant fails to report any required Current Earnings information; or
- f. the date the Participant fails to report income from Other Income Sources; or
- g. the date ten days after receipt of notice from The Principal if the Participant fails to pursue Social Security Benefits or benefits under a Workers' Compensation Act or similar law as outlined in this PART IV, Section Q, Article(s) 8 and 9; or
- h. if Disability results from alcohol, drug or chemical abuse, dependency, or addiction, *[or]* a Mental Health Condition *[or a Special Condition]*, the date 24 months after the Benefit Payment Period begins; or
- [17]* i. *[if Disability results from a Special Condition, the date [12] months after the Benefit Payment Period begins; or]*
- j. the date the Participant ceases to be under the Regular and Appropriate Care of a Physician.

## **Article 2 - Recurring Disability**

A Recurring Disability will exist under this Group Policy if:

- a. after completing an Elimination Period and during a Benefit Payment Period, a Participant ceases to be Disabled; and
- b. the Participant then returns to Active Work; and
- c. while insured under this Group Policy, but before completing six continuous months of Active Work, the Participant is again Disabled; and
- d. the current Disability and the Disability for which the Elimination Period was completed result from the same or a related cause.

A Recurring Disability will be treated as if the initial Disability had not ended, except that no benefits will be payable for the time between Disabilities. The Participant will not be required to complete a new Elimination Period. Benefits will be payable from the first day of each Recurring Disability, but only for the remainder, if any, of the Benefit Payment Period established for the initial Disability.

## **PART IV - BENEFITS**

## PART IV - BENEFITS

### Section N

#### Treatment of Alcohol, Drug or Chemical Abuse, Dependency, or Addiction, a Mental Health Condition, or a Special Condition

##### Article 1 - Treatment of Alcohol, Drug or Chemical Abuse, Dependency, or Addiction, a Mental Health Condition or a Special Condition

The Participant's period of Disability will be considered due to alcohol, drug or chemical abuse, dependency, or addiction, a Mental Health Condition or a Special Condition if:

- a. the Participant is limited by one or more of the stated conditions; and
- b. the Participant does not have other conditions which, in the absence of the above stated conditions, would continue to exist, limit activities and lead The Principal to conclude that the Participant is Disabled for another condition in and of itself.

When Disability results from alcohol, drug or chemical abuse, dependency, or addiction, *[or]* a Mental Health Condition *[or a Special Condition]*, a Participant's maximum number of Benefits Payable for all such periods of Disability is limited to 24 months. This is not a separate maximum for each such condition, or for each period of Disability, but a combined lifetime maximum for all periods of Disability and for all of these conditions, either separate or combined.

However, if at the end of that 24 months, the Participant is confined in a Hospital or other facility qualified to provide necessary care and treatment for alcohol, drug or chemical abuse, dependency, or addiction, *[or]* a Mental Health Condition *[or a Special Condition]*, then the Benefit Payment Period may be extended to include the time during which the Participant remains confined.

*[17]*

*[When Disability results from a Special Condition a Member's maximum number of Benefits Payable for all such periods of Disability is limited to [12] months. This is not a separate maximum for each such condition, or for each period of Disability, but a combined lifetime maximum for all periods of Disability and for all of these conditions, either separate or combined.]*

*However, if at the end of that [12] months, the Member is confined in a Hospital or other facility qualified to provide necessary care and treatment for a Special Condition, then the Benefit Payment Period may be extended to include the time during which the Member remains confined.]*

## PART IV - BENEFITS

#### GC 3044 DIL-1 Section N - Treatment of Alcohol, Drug or Chemical Abuse, Dependency, or Addiction, a Mental Health Condition, or a Special Condition

Benefits will be payable for the length of the confinement and for up to 60 days following the end of the confinement. If the Participant is Hospital confined again during the 60-day period for at least ten consecutive days, benefits will be payable for the length of the second confinement and for up to 60 days following the end of the second confinement.

#### **PART IV - BENEFITS**

**GC 3044 DIL-1    Section N - Treatment of Alcohol, Drug or Chemical Abuse, Dependency, or Addiction, a Mental Health Condition, or a Special Condition**

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**H35978**

Who Pays for Coverage	You are required to pay the entire premium for insurance under the Group Policy.	
Elimination Period	the greater of salary continuance or [90 days]	
Own Occupation Period	to Social Security Normal Retirement Age with Residual Disability	
Primary Monthly Benefit	[60%] of your Predisability Earnings.	
Maximum Monthly Benefit	[\$25,000]	
Minimum Monthly Benefit	the greater of [10%] of your Primary Monthly Benefit or [\$100]	
Maximum Benefit Payment Period	Participant's Age on The Date Disability <u>Begins</u> Before age 65	Months of the Benefit Payment <u>Period</u> greater of 36 Months or to Social Security Normal Retirement Age
	65-67	24 months
	68-69	18 months
	70-71	15 months
	72 and over	12 months
Rehabilitation Services and Benefits		
Rehabilitation Services	Included	
Predisability Intervention Services	Included	
Rehabilitation Incentive Benefit	[10%]	
Reasonable Accommodation Benefit	[\$2,000]	
Other Coverage Features		
Work Incentive Benefit	[24] months	
Survivor Benefit	[three] times Primary Monthly Benefit	
<b>NOTE:</b>		
No premiums are required during a Long Term Disability Benefit Payment Period.		
Benefits may be reduced by other sources of income and disability earnings.		
Some disabilities may not be covered or may be limited under this insurance.		

**H35979**

Who Pays for Coverage	You are required to pay the entire premium for insurance under the Group Policy.	
Elimination Period	the greater of salary continuance or [90 days]	
Own Occupation Period	to Social Security Normal Retirement Age with Residual Disability	
Primary Monthly Benefit	[60%] of your Predisability Earnings.	
Maximum Monthly Benefit	[\$15,000]	
Minimum Monthly Benefit	the greater of [10%] of your Primary Monthly Benefit or [\$100]	
Maximum Benefit Payment Period	Participant's Age on The Date Disability <u>Begins</u> Before age 65  65-67 68-69 70-71 72 and over	Months of the Benefit Payment <u>Period</u> greater of 36 Months or to Social Security Normal Retirement Age 24 months 18 months 15 months 12 months
Rehabilitation Services and Benefits		
Rehabilitation Services	Included	
Predisability Intervention Services	Included	
Rehabilitation Incentive Benefit	[10%]	
Reasonable Accommodation Benefit	[\$2,000]	
Other Coverage Features		
Work Incentive Benefit	[24] months	
Survivor Benefit	[three] times Primary Monthly Benefit	
<b>NOTE:</b>		
No premiums are required during a Long Term Disability Benefit Payment Period.		
Benefits may be reduced by other sources of income and disability earnings.		
Some disabilities may not be covered or may be limited under this insurance.		

This summary provides only highlights of the Group Policy. The entire Group Policy determines all rights, benefits, exclusions and limitations of the insurance described above.

## **/DESCRIPTION OF BENEFITS**

### **Survivor Benefit and Accelerated Survivor Benefit**

#### **Survivor Benefit**

In the event a Benefit Payment Period ends because of your death, a Survivor Benefit will be payable. This Survivor Benefit will be [three] times your Primary Monthly Benefit.

Principal Life will pay the Survivor Benefit to your spouse, child, parent, or estate as described in the CLAIM PROCEDURES Section.

#### **Accelerated Survivor Benefit**

##### **Definition of Terminally Ill**

You will be considered Terminally Ill under the Group Policy if you are expected to die within 12 months of the date you request payment of the Accelerated Survivor Benefit.

##### **Eligibility**

Principal Life will pay you an Accelerated Survivor Benefit if you request such payment and meet the following requirements. You must:

- a. satisfy the Benefit Qualifications listed in this booklet-certificate; and
- b. provide proof that you are Terminally Ill by submitting to Principal Life:
  - (1) a statement from your Physician; and
  - (2) any other medical information that Principal Life believes necessary to confirm your status; and
- c. be living on the date of payment of the Accelerated Survivor Benefit.

##### **Benefit**

If you qualify, Principal Life will pay an Accelerated Survivor Benefit. This benefit will be equal to [three] times your Primary Monthly Benefit and will be paid to you in a single lump sum. This benefit is paid in addition to your regular Benefit Payable.

##### **Effect on Survivor Benefit**

If an Accelerated Survivor Benefit is paid, no Survivor Benefit will be payable./

## DESCRIPTION OF BENEFITS

### Benefit Payment Period and Recurring Disability

#### Benefit Payment Period

Benefits are payable:

- a. if your Disability begins before you are age 65, until the later of the date 36 months after your Benefit Payment Period begins, or the date you attain Social Security Normal Retirement Age; or
- b. if your Disability begins on or after you are age 65, *[until the later of the date of Social Security Normal Retirement Age], or [until] the date of completion of the number of months shown below after your Benefit Payment Period begins:*

<u>Your Age on the Date Disability Begins</u>	<u>Months of the Benefit Payment Period (Beginning with the date the Benefit Payment Period begins)</u>
<i>[65, 66, 67</i>	24
68, 69	18
70, 71	15
72 and over	<i>12]</i>
<i>[62</i>	42
63	36
64	30
65	24
66	21
67	18
68	15
69 and over	<i>12]</i>

However, in no event, will benefits continue beyond:

- a. the date of your death; or
- b. the date your Disability ends, unless a Recurring Disability exists as explained in this booklet-*certificate*; or
- c. the date you fail to provide any required proof of Disability; or
- d. the date you fail to submit to any required medical examination or evaluation; or

- e. the date you fail to report any required Current Earnings information; or
- f. the date you fail to report income from Other Income Sources; or
- g. the date ten days after receipt of notice from *Principal Life* if you fail to pursue Social Security Benefits or benefits under a Workers' Compensation Act or similar law as described in this booklet-*certificate*; or
- h. if Disability results from alcohol, drug or chemical abuse, dependency, or addiction, *[or]* a Mental Health Condition *[or a Special Condition]*, the date 24 months after the Benefit Payment Period begins; or
- i. *[if Disability results from a Special Condition, the date [12] months after the Benefit Payment Period begins; or]*
- j. the date you cease to be under the Regular and Appropriate Care of a Physician.

### **Recurring Disability**

A Recurring Disability will exist under the Group Policy if:

- a. after you have completed an Elimination Period and during a Benefit Payment Period, you cease to be Disabled; and
- b. you then return to Active Work; and
- c. while insured under the Group Policy but before completing six continuous months of Active Work, you are again Disabled; and
- d. your current Disability and the Disability for which you completed the Elimination Period result from the same or a related cause.

A Recurring Disability will be treated as if the initial Disability had not ended, except that no benefits will be payable for the time between Disabilities. You will not be required to complete a new Elimination Period. Benefits will be payable from the first day of each Recurring Disability, but only for the remainder, if any, of the Benefit Payment Period established for the initial Disability.

## DESCRIPTION OF BENEFITS

### **Treatment of Alcohol, Drug or Chemical Abuse, Dependency, or Addiction, a Mental Health Condition, or a Special Condition**

Your period of Disability will be considered due to alcohol, drug or chemical abuse, dependency, or addiction, a Mental Health Condition or a Special Condition if:

- a. you are limited by one or more of the stated conditions; and
- b. you do not have other conditions which, in the absence of the above stated conditions, would continue to exist, limit activities and lead Principal Life to conclude that you are Disabled for another condition in and of itself.

When Disability results from alcohol, drug or chemical abuse, dependency, or addiction, *[or]* a Mental Health Condition *[or a Special Condition]*, the maximum number of Benefits Payable for all such periods of Disability is limited to 24 months. This is not a separate maximum for each such condition, or for each period of Disability, but a combined lifetime maximum for all periods of Disability and for all of these conditions, either separate or combined.

However, if at the end of that 24 months, you are confined in a Hospital or other facility qualified to provide necessary care and treatment for alcohol, drug or chemical abuse, dependency, or addiction, *[or]* a Mental Health Condition *[or a Special Condition]*, then the Benefit Payment Period may be extended to include the time during which you remain confined.

*[When Disability results from a Special Condition, the maximum number of Benefits Payable for all such periods of Disability is limited to [12] months. This is not a separate maximum for each such condition, or for each period of Disability, but a combined lifetime maximum for all periods of Disability and for all of these conditions, either separate or combined.]*

*However, if at the end of that [12] months, you are confined in a Hospital or other facility qualified to provide necessary care and treatment for a Special Condition, then the Benefit Payment Period may be extended to include the time during which you remain confined.]*

Benefits will be payable for the length of the confinement and for up to 60 days following the end of the confinement. If you are Hospital confined again during the 60-day period for at least ten consecutive days, benefits will be payable for the length of the second confinement and for up to 60 days following the end of the second confinement.

SERFF Tracking Number: PRLF-126245114 State: Arkansas  
 Filing Company: Principal Life Insurance Company State Tracking Number: 43446  
 Company Tracking Number:  
 TOI: H11G Group Health - Disability Income Sub-TOI: H11G.003 Long Term  
 Product Name: Dillard's - LTD - Revisions  
 Project Name/Number: /

## Supporting Document Schedules

		<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b>	Flesch Certification	Approved-Closed	09/23/2009
<b>Comments:</b>			
<b>Attachment:</b>			
Readability Cert.pdf			

		<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b>	Application	Approved-Closed	09/23/2009
<b>Comments:</b>			
This was previously approved on 6-9-2008 (State Tracking Number 39165)			
<b>Attachment:</b>			
GP56002.pdf			

		<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b>	LTD Footnotes	Approved-Closed	09/23/2009
<b>Comments:</b>			
<b>Attachment:</b>			
LTD Footnotes.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 3001 DIL-1, GC 3002 DIL-1, GC 3026 DIL-1, GC 3042 DIL-1, GC 3044 DIL-1	Group Long Term Disability Policy Forms	52.7
GH 801 DIL-1, GH 802 DIL-1, GH 811 DIL-1, GH 819 DIL-1, GH 820 DIL-1	Group Long Term Disability Booklet-Certificate Forms	50.1

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

September 8, 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 <b>currently</b> receiving medical treatment, taking medication, or pregnant?																				
3.	yes	no	<b>In the past 5 years</b> , 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	<b>In the past 5 years</b> , 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																				
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																							
5.	yes	no	<b>In the past 10 years</b> , 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		

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		

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.

**Explanatory Footnotes for Submission of Group Long Term Disability Insurance Policy  
Forms, GC 3000 DIL, et al**

**Policy Form GC 3026 DIL-1**

[12] The Survivor Benefit and Accelerated Survivor Benefit *will be* standard provisions for Participants *covered under H 35978 and H 35979 only*. The [three] variable is currently used, but may be changed if requested and agreed to by The Principal and the policyholder.

**Policy Form GC 3042 DIL-1**

[16] *The variable text will only be used for Participants covered under plan H 35922 only.*

[17] *The variable text will only be used for Participants covered under plan H 35922. The [12] variable will be standardly used.*