

SERFF Tracking Number: PRLF-126823788 State: Arkansas
Filing Company: Principal Life Insurance Company State Tracking Number: 46871
Company Tracking Number:
TOI: H11G Group Health - Disability Income Sub-TOI: H11G.003 Long Term
Product Name: Single Case Filing - Group Long Term Disability- AR
Project Name/Number: /

Filing at a Glance

Company: Principal Life Insurance Company

Product Name: Single Case Filing - Group Long SERFF Tr Num: PRLF-126823788 State: Arkansas

Term Disability- AR

TOI: H11G Group Health - Disability Income SERFF Status: Closed-Approved- State Tr Num: 46871
Closed

Sub-TOI: H11G.003 Long Term Co Tr Num: State Status: Approved-Closed
Filing Type: Form Reviewer(s): Rosalind Minor

Authors: Donna Burns, Mark Curtis, Disposition Date: 10/06/2010
Ann McCoy

Date Submitted: 09/22/2010 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: Not required to be
filed in Iowa

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: 10/06/2010

Explanation for Other Group Market Type:

State Status Changed: 10/06/2010

Deemer Date:

Created By: Ann McCoy

Submitted By: Ann McCoy

Corresponding Filing Tracking Number:

Filing Description:

Principal Life Insurance Company

NAIC No. 61271-332

FEIN # 42-0127290

Group Long Term Disability

Policy Forms GC 3012-2 DIL-1

Booklet-Certificate Forms GH 804-2 DIL-1

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Attached 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 changes to their Eligibility Requirements for participants. 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 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 Long Term Disability filing for this policyholder, SERFF Tracking Number PRLF – 126245114 and was approved on September 23, 2009.

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 attached.

Company and Contact

Filing Contact Information

Ann McCoy, State/Federal Compliance Analyst mccoey.ann@principal.com
711 High St. 800-986-3343 [Phone] 89658 [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

SERFF Tracking Number: PRLF-126823788 State: Arkansas
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Fee Required? Yes
Fee Amount: \$50.00
Retaliatory? No
Fee Explanation: 1 Form filing = \$50.00
Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Principal Life Insurance Company	\$50.00	09/22/2010	39766960
Principal Life Insurance Company	\$50.00	09/27/2010	39904066

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	10/06/2010	10/06/2010

Filing Notes

Subject	Note Type	Created By	Created On	Date Submitted
Additional Fees	Note To Reviewer	Ann McCoy	09/27/2010	09/27/2010

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Disposition

Disposition Date: 10/06/2010

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	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Cover Letter	Approved-Closed	Yes
Form	PART III - INDIVIDUAL REQUIREMENTS AND RIGHTS	Approved-Closed	Yes
Form	HOW TO BE INSURED	Approved-Closed	Yes

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Note To Reviewer

Created By:

Ann McCoy on 09/27/2010 07:52 AM

Last Edited By:

Rosalind Minor

Submitted On:

10/06/2010 01:44 PM

Subject:

Additional Fees

Comments:

I have submitted an additional \$50.00 to comply with Regulation 57.

Please let me know if any additional information is needed for your review of this filing.

Thank you

Ann McCoy

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Form Schedule

Lead Form Number:

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 10/06/2010	GC 3012-2 DIL-1	Policy/Cont ract/Fratern al	PART III - INDIVIDUAL REQUIREMENTS Certificate: AND RIGHTS Amendmen t, Insert Page, Endorseme nt or Rider	Revised	Replaced Form #: GC 3012-1 DIL Previous Filing #: PRLF-125595399	52.700	GC 3012-2 DIL-1.pdf
Approved-Closed 10/06/2010	GH 804-2 DIL-1	Certificate Amendmen t, Insert Page, Endorseme nt or Rider	HOW TO BE INSURED	Revised	Replaced Form #: GH 804-1 DIL Previous Filing #: PRLF-125595399	50.100	GH 804-2 DIL-1.pdf

PART III - INDIVIDUAL REQUIREMENTS AND RIGHTS

Section A

Eligibility

Article 1 - Participant Insurance

A person will be eligible for insurance on the later of:

- a. the Date of Issue of this Group Policy; or
- b. the 1st day of the month *according to Dillard's accounting calendar in which the Participant meets* eligibility and *has enrolled in coverage*. Eligibility will be determined by Dillard's.

PART III - INDIVIDUAL REQUIREMENTS AND RIGHTS

**HOW TO BE INSURED
LONG TERM DISABILITY INSURANCE**

Eligibility and Individual Incontestability

Eligibility

You will be eligible for insurance on the later of:

- a. June 1, 2006, if you are a Participant on that date; or
- b. the 1st day of the month *according to Dillard's accounting calendar in which the Participant meets* eligibility and *has enrolled in coverage*. Eligibility will be determined by Dillard's.

Individual Incontestability

All statements made by any person insured will be representations and not warranties. In the absence of fraud, these statements may not be used to contest the Participant's coverage unless:

- a. the insurance has been in force for less than two years during the Participant's lifetime; and
- b. the statement is in Written form Signed by the Participant; and
- c. a copy of the form which contains the statement is given to the Participant or the Participant's beneficiary at the time insurance is contested.

However, the above will not preclude the assertion at any time of defenses based upon the person's not being eligible for insurance under the Group Policy or upon other provisions of the Group Policy.

In addition, if a person's age is misstated, Principal Life may, at any time, adjust premiums and benefits to reflect the correct age.

Principal Life may, at any time, terminate a Participant 's eligibility under the Group Policy in Writing and with 31 day notice:

- a. if the individual submits any claim that contains false or fraudulent elements under state or federal law;
- b. upon finding in a civil or criminal case that a Participant has submitted claims that contain false or fraudulent elements under state or federal law;

- c. when a Participant has submitted a claim which, in good faith judgment and investigation, a Participant knew or should have known, contains false or fraudulent elements under state or federal law.

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Supporting Document Schedules

	Item Status:	Status Date:
Satisfied - Item: Flesch Certification	Approved-Closed	10/06/2010
Comments:		
Attachment: Readability Cert.pdf		

	Item Status:	Status Date:
Satisfied - Item: Application	Approved-Closed	10/06/2010
Comments: Will use the application form GP56002 that was included with the filing PRLF-126150601 and that filing was approved on September 23, 2009. Attached for informational purposes.		
Attachment: GP56002.pdf		

	Item Status:	Status Date:
Satisfied - Item: Cover Letter	Approved-Closed	10/06/2010
Comments:		
Attachment: Submission Letter.pdf		

**STATE OF ARKANSAS
INSURANCE DEPARTMENT**

CERTIFICATION OF READABILITY

I, Kimberly Douglas, 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 3012-2 DIL-1	PART III - INDIVIDUAL REQUIREMENTS AND RIGHTS Section A Eligibility	52.7
GH 804-2 DIL-1	HOW TO BE INSURED LONG TERM DISABILITY INSURANCE Eligibility and Individual Incontestability	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



Kimberly Douglas, Director
Group Life and Health Compliance

September 22, 2010

Date

12/1999





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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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.



**Principal Life
Insurance Company**

September 22, 2010

Arkansas Insurance Department
Life and Health Division
1200 West Third Street
Little Rock, AR 72201-1904

RE Group Long Term Disability
Policy Forms GC 3012-2 DIL-1
Booklet-Certificate Forms GH 804-2 DIL-1
Principal Life Insurance Company
NAIC No. 61271-332
FEIN # 42-0127290

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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 attached.

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

Sincerely

A handwritten signature in black ink that reads "Ann McCoy".

Ann McCoy
State/Federal Compliance Analyst
Group Life & Health Compliance
Principal Life Insurance Company
Des Moines, IA 50392-0002
Phone 515-248-9658
Fax – 515-246-2491
E-mail address: mccoy.ann@principal.com
Attachments