

SERFF Tracking Number: PRLF-126826341 State: Arkansas  
Filing Company: Principal Life Insurance Company State Tracking Number: 46875  
Company Tracking Number:  
TOI: H10G Group Health - Dental Sub-TOI: H10G.000 Health - Dental  
Product Name: Single Case Filing - Dental - H62948- AR  
Project Name/Number: /

## Filing at a Glance

Company: Principal Life Insurance Company

Product Name: Single Case Filing - Dental - H62948- AR SERFF Tr Num: PRLF-126826341 State: Arkansas

TOI: H10G Group Health - Dental SERFF Status: Closed-Approved- Closed State Tr Num: 46875

Sub-TOI: H10G.000 Health - Dental Co Tr Num: State Status: Approved-Closed  
Filing Type: Form Reviewer(s): Rosalind Minor

Authors: Donna Burns, Mark Curtis, Disposition Date: 10/07/2010  
Ann McCoy

Date Submitted: 09/23/2010 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: N/A 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: 10/07/2010

Explanation for Other Group Market Type:

State Status Changed: 10/07/2010

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 Term Life Insurance

Policy Forms - GC 7006 DIL

Booklet Certificate Form – GH 1003 DIL

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Attached for your review and approval are 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. The changes are italicized and in red font on the attached policy and booklet certificate insert pages for your ease in reviewing. These are new forms and are not replacing any forms previously approved.

If approved, these pages will be used for this one case only, with our Group Dental Insurance Policy forms series GC 7000, et al, and GH 1000, et al., which were originally filed and approved in your state on July 2, 2003, with subsequent revisions also filed and approved.

This policyholder has also requested use of the enclosed enrollment form GP 45697-6 specific to their group.

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 mccooy.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

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## Filing Fees

Fee Required? Yes  
Fee Amount: \$50.00  
Retaliatory? No



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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	10/07/2010	10/07/2010

### Filing Notes

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

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## Disposition

Disposition Date: 10/07/2010

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 - MEMBERS	Approved-Closed	Yes

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**Note To Reviewer**

**Created By:**

Ann McCoy on 09/27/2010 07:53 AM

**Last Edited By:**

Rosalind Minor

**Submitted On:**

10/07/2010 12:42 PM

**Subject:**

Additional Filing 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 10/07/2010	GC 7006 DIL	Policy/Cont ract/Fratern al	PART III - INDIVIDUAL REQUIREMENTS Certificate: AND RIGHTS Amendmen t, Insert Page, Endorseme nt or Rider	Initial		53.500	GC 7006 DIL.pdf
Approved-Closed 10/07/2010	GH 1003 DIL	Certificate Amendmen t, Insert	HOW TO BE INSURED - MEMBERS	Initial		51.100	GH 1003 DIL.pdf

## **PART III - INDIVIDUAL REQUIREMENTS AND RIGHTS**

### **Section A - Eligibility**

#### **Article 1 - Member Dental Expense Insurance**

A person will be eligible for Member Dental Expense Insurance on the *1st day of the month according to Dillard's accounting calendar in which the Member meets eligibility and has enrolled in coverage. Eligibility will be determined by Dillard's.*

If a Member elects to waive coverage under this Group Policy because he or she is covered under group dental expense coverage or coverages provided by the Dependent's employer, the date such coverage terminates because the Dependent is no longer eligible under his/her employer's coverage will be considered the date the Member is eligible to request insurance as described in PART III, Section B of this Group Policy.

#### **Article 2 - Dependent Dental Expense Insurance**

A person will be eligible for Dependent Dental Expense Insurance on the later of:

- a. the date the person is eligible for Member Dental Expense Insurance; or
- b. the date the person first acquires a Dependent.

A Member may elect to waive coverage for his/her Dependent Child until 31 days after the child's third birthday.

If request for coverage is more than 31 days after the Dependent Child's third birthday, benefits will be limited as described in this PART III, Section B, Article 3.

If a Member's Dependent is employed and covered under group dental expense coverage or coverages provided by the Dependent's employer, the date such coverage terminates because the Dependent is no longer eligible under his/her employer's coverage will be considered the date the Member first acquires that Dependent (and any other Dependent who was also covered under such group coverage or coverages).

## **PART III - INDIVIDUAL REQUIREMENTS AND RIGHTS**

**HOW TO BE INSURED - MEMBERS**  
**DENTAL EXPENSE INSURANCE**

**Eligibility**

To be eligible for insurance you must be a Member.

**Member** means any HIGH PLAN PERSON who is a Full-Time Employee of the Policyholder.

You will be eligible on the *1st day of the month according to Dillard's accounting calendar in which the Member meets eligibility and has enrolled in coverage. Eligibility will be determined by Dillard's.*

If you elect to waive insurance under the Group Policy because you are covered under group dental expense coverage or coverages provided by your Dependent's employer, the date such coverage terminates because your Dependent is no longer eligible under his/her employer's coverage will be considered the date you are eligible to request insurance as described in this section.

**Effective Dates - Actively at Work**

If you are not Actively at Work on the date your insurance would otherwise be effective, your insurance will not be in force until the day you return to Active Work.

This Actively at Work requirement will be waived for you if:

- you are absent from Active Work because of a regularly scheduled day off, holiday, or vacation day; and
- you were Actively at Work on your last scheduled work day before the date of your absence; and
- you were capable of Active Work on the day before the scheduled effective date of your insurance or change in your insurance, whichever is applicable.

**Individual Incontestability and Eligibility**

All statements made by any person insured (you or one of your Dependents) will be representations and not warranties. In the absence of fraud, these statements may not be used to contest the insured person's insurance unless:

- the insurance has been in force for less than two years during the insured person's lifetime; and

- the statement is in Written form Signed by the insured person; and
- a copy of the form which contains the statement is given to the insured person or the insured person'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, We may, at any time, adjust premiums and benefits to reflect the correct age.

We may at any time terminate a person's eligibility under the Group Policy:

- in Writing and with 31-day notice, if the individual submits any claim that contains false or fraudulent elements under state or federal law; or
- in Writing and with 31-day notice, upon finding in a civil or criminal case that an individual has submitted claims that contain false or fraudulent elements under state or federal law; or
- in Writing and with 31-day notice, when an individual has submitted a claim which, in good faith judgment and investigation, an individual knew or should have known, contains false or fraudulent elements under state or federal law.

### **Effective Date for Noncontributory Insurance**

Insurance for which you contribute no part of the premium will become effective on the date you are eligible.

### **Effective Date for Contributory Insurance**

If you are required to contribute towards the cost of your insurance, you must request insurance in a form approved by Us. The requested insurance will become effective on:

- the first of the Insurance Month coinciding with or next following the date you are eligible, if you make your request on or before that date; or
- the first of the Insurance Month coinciding with or next following the date you are eligible, if you make your request within 31 days after the date you are eligible; or
- the later of: (1) the date all other insurance under your plan is effective for you; or (2) the first of the Insurance Month coinciding with or next following the date of your request, if you make your request more than 31 days after the date you are eligible.

If request for insurance is made more than 31 days after the date an individual is eligible but as a result of a Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN), insurance for such individual will become effective as described below.

If request for contributory insurance is made more than 31 days after the date an individual is eligible but during a Annual Enrollment Period or Special Enrollment Period described below, insurance for such individual will become effective as described below under "Annual Enrollment Period" or "Special Enrollment Period".

However, if you are not Actively at Work on the date insurance would otherwise be effective, your insurance will not be in force until the date you return to Active Work.

In addition, your Dental Expense Insurance will be subject to the Benefit Waiting Period Limits described on page GH 1007.

**Court Ordered Coverage Under a Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN): Benefit Waiting Period provisions as described on page GH 1007 will not apply to you or your Dependent Child if:**

- you are enrolled (or eligible to be enrolled but have failed to enroll during a previous enrollment period); and
- you failed to enroll your Dependent Child during a previous enrollment period; and
- you are required by a QMCSO or NMSN as defined by applicable federal law and state insurance laws to provide dental coverage to your Dependent Child.

The request for enrollment:

- may be made at any time after the issue date of the QMCSO or NMSN; and
- will apply only to you and/or your Dependent Child(ren) listed in the QMCSO or NMSN.

The effective date for your or your Dependent Child's insurance:

- will be the first of the Insurance Month coinciding with or next following the date of the request for enrollment; and
- will not be subject to the Actively at Work provisions described in this section.

A request for enrollment for any Dependent not listed in the QMCSO or NMSN will be subject to the regular effective date provisions of the Group Policy.

A copy of the procedures governing qualified medical child support orders (QMCSO) can be obtained from the plan administrator without charge.

## **Annual Enrollment Period**

An Annual Enrollment Period will be available for any Member or Dependent who failed to enroll:

- during the first period in which he or she was eligible to enroll, or during any subsequent Special Enrollment Period as described below; or
- during any previous Annual Enrollment Period.

For any Member or Dependent not previously insured under the Group Policy, the Benefit Waiting Period provisions described on GH 1007 do not apply during the Annual Enrollment Period.

To qualify for enrollment during the Annual Enrollment Period, you or your Dependent:

- must meet the eligibility requirements described in the Group Policy, including satisfaction of any applicable waiting period; and
- may not be covered under an alternate dental expense coverage offered by the Policyholder, unless the Annual Enrollment Period happens to coincide with a separate open enrollment period established for coverage election.

The Annual Enrollment Period is generally the one-month period immediately prior to the Policy Anniversary date or another period of time requested by the Policyholder and approved by Us. The Annual Enrollment Period is the period from May 1 through May 31.

The effective date for any qualified individual requesting insurance during the Annual Enrollment Period will be on June 1 following completion of the Annual Enrollment Period provided contribution has been received for the requested insurance.

## **Special Enrollment Period**

A Special Enrollment Period, as described below, will be available for you or your Dependent if enrollment is made after the first period in which you or your Dependent are eligible to enroll.

The Special Enrollment Periods are:

- Loss of Other Coverage: A Special Enrollment Period will apply to you or your Dependent if all of the following conditions are met:
  - (i) the individual was covered under another group dental expense coverage at the time of his or her initial eligibility, and declined enrollment solely due to the other coverage; and

- (ii) the other coverage terminated due to loss of eligibility (including loss due to divorce or legal separation, death, termination of employment or reduction in work hours, or if the other coverage was under a COBRA or state continuation provision, due to exhaustion of the continuation); and
- (iii) request for enrollment is made within 31 days after the other coverage terminates.

The effective date of insurance will be the first of the Insurance Month coinciding with or next following the date of the request for enrollment provided contribution has been received for the requested insurance.

NOTE: For the purpose of (ii) above:

"Loss of eligibility" does not include:

- (i) a loss due to failure of the individual to pay premiums on a timely basis or termination of insurance for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the dental expense coverage); or
- (ii) a loss due to a spouse's voluntary termination of his or her dental expense coverage; or
- (iii) a loss due to a spouse's voluntary termination of his or her Dependent dental expense coverage.

- Newly Acquired Dependents: A Special Enrollment Period will apply to you or your Dependent if:

- (i) you are enrolled (or are eligible to be enrolled but have failed to enroll during a previous enrollment period); and
- (ii) a person becomes your Dependent through marriage, birth, adoption or placement for adoption; and
- (iii) request for enrollment is made within 31 days after the date of the marriage, birth, adoption or placement for adoption, or the date Dependent Dental Expense Insurance is available to the Member under the Group Policy, if the request is made on or before the event or within 31 days after the event.

The effective date of your or your Dependent's insurance will be:

- (i) in the event of marriage, the date of such marriage; or
- (ii) in the event of a Dependent Child's birth, the date of such birth; or
- (iii) in the event of a Dependent Child's adoption or placement for adoption, the date of such adoption or placement for adoption, whichever is earlier.

During a Special Enrollment Period, your Dental Expense Insurance will not be subject to the Benefit Waiting Period Limits described on GH 1007.

## **Effective Date for Benefit Changes**

A change in your Scheduled Benefit amount because of a change in your status (insurance class) will normally be effective on the first of the Insurance Month coinciding with or next following the date of the change in status.

A change in your Scheduled Benefit amount because of a change in benefits provided under the Group Policy will normally be effective on the first of the Insurance Month coinciding with or next following the date of the change.

However, if you are not Actively at Work on the date the change would otherwise be effective, the change will not be in force until the day you return to Active Work.

## **Termination**

Unless continued as provided below or on GH 1005 A, GH 1005 B, GH 1005 C, and GH 1005 D, your insurance under the Group Policy will cease on the earliest of:

- the date the Group Policy terminates; or
- the date the last contribution is made for your insurance; or
- for contributory insurance any date desired, if requested by you before that date; or
- the date you cease to belong to a class for which insurance is provided; or
- the date you cease to be a Member; or
- the date you cease Active Work.

## **Continuation**

If you cease Active Work because of sickness or injury, you may be eligible for limited continuation of insurance until the earlier of the date you recover or the date insurance would otherwise terminate as described above.

If you cease Active Work because of layoff or leave of absence, insurance may be continued on a limited basis.

In addition, by paying the required contribution, if any, your insurance may be continued under the continuation provisions described on GH 1005 A, GH 1005 B, GH 1005 C, and GH 1005 D.

If you are interested in continuing your insurance beyond the date it would normally terminate, you should consult with the Policyholder before your insurance terminates.

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## Supporting Document Schedules

		<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b>	Flesch Certification	Approved-Closed	10/07/2010
<b>Comments:</b>			
<b>Attachment:</b>			
Readability Cert.pdf			

		<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b>	Application	Approved-Closed	10/07/2010
<b>Comments:</b>			
<b>Attachment:</b>			
Dental app.pdf			

		<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b>	Cover Letter	Approved-Closed	10/07/2010
<b>Comments:</b>			
<b>Attachment:</b>			
Dental Cover 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 7006 DIL	<b>PART III - INDIVIDUAL REQUIREMENTS AND RIGHTS</b> Section A - Eligibility	53.5
GH 1003 DIL	<b>HOW TO BE INSURED - MEMBERS DENTAL EXPENSE INSURANCE</b>	51.1

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 23, 2010

Date

12/1999

**Principal**<sup>®</sup>  
*Financial  
Group*

Mailing Address: Des Moines, IA 50392-0002

Principal Life Insurance Company

Employer Application for Group Insurance - AR

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

This form is for: [X] new case [ ] amendment (only complete sections with changes) Account number H62948

Requested effective date: 6/1/2009

Advance premium received \$ 0.00

Employer Information

Legal name of company

Dillard's, Inc. Flex Benefit Plans

DBA name (if applicable)

- [X] C-corporation [ ] S-corporation [ ] limited liability company [ ] partnership [ ] sole proprietorship [ ] other

Physical street address: 1600 Cantrell Rd, City: Little Rock, State: AR, ZIP code: 72201

Billing/mailing address (P O box): Same, City: , State: , ZIP code:

Group contact name: Tammy Barnes, Telephone number: (501) 376-5000, FAX number: (501) 210-5554, E-mail address: tammy.barnes@dillards.com

Billing contact name (if different): Same, Nature of business or SIC code: Retail/5651, Federal tax ID number: 71-0388071, Date company established: 50+

Have you been insured by Principal Life Insurance Company previously? [X] yes [ ] no

If yes, when and under what name? Same

Has the company been denied credit within the past two years, ever filed for bankruptcy, or is the firm now in the process of (or considering) filing for bankruptcy? [ ] yes [X] no

Have you elected a Health Reimbursement Arrangement with Principal Life? [ ] yes [X] no

Have you elected a Health Savings Account with Principal Life? [ ] yes [X] no

Complete the following if this coverage replaces other group insurance. Provide a copy of a recent billing and contract.

Note: Include prior carrier information for past three years.

Table with 4 columns: Name of Carrier, Coverage(s), Effective Date, Termination Date or Date Due to Terminate. Row 1: CIGNA, Dental, , 5/31/2009

Employers with Multiple Locations or Participating Units

Does your business have more than one physical location? [X] yes [ ] no If yes, list with complete addresses: provided under separate cover

Is Division Billing requested? [ ] yes [X] no If yes, indicate on enrollment materials which division or unit for each employee.

Are multiple bills requested? [ ] yes [X] no (billing limitations may apply)

Are employees of any associated business organizations (e.g parent-subsidiary, brother-sister relationships, affiliated groups, etc.) to be covered? [ ] yes [X] 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.

Table with 5 columns: Unit name/address/federal tax ID, Nature of business, Relationship to company, include/exclude unit, Number of employees. Row 1: CDI Contractors, Construction, Dillard's owns, [X] exclude unit, 300

**Request for Benefits**

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Illustrated in proposal number 02190911204

Version number 7

Dental/vision/medical: Do you want insurance for.  employees  employees and dependents

If different by coverage, list: \_\_\_\_\_

- dental  voluntary dental  vision  voluntary vision  
 basic term life, options.  accidental death and dismemberment  accelerated death benefits  dependent life  
 voluntary term life, options.  accidental death and dismemberment  accelerated death benefits  
 short term disability  voluntary short term disability  long term disability  voluntary long term disability  
 If voluntary elected, verify billing mode:  monthly  semi-monthly  weekly  bi-weekly  
 (some billing options may not be available)

If voluntary elected, please provide last payroll date prior to effective date \_\_\_\_\_

medical: PPO number(s)/name(s) \_\_\_\_\_

If benefits differ by job class, please specify \_\_\_\_\_

**Waiting Period (the length of time new employees must be employed before becoming eligible for insurance)**

\_\_\_\_\_ days or 1 months or  none

Should all employees hired on or before the effective date be enrolled on the group's effective date?  yes  no

If waiting period is different by job class, please specify \_\_\_\_\_

What day will employees be eligible?

- day immediately following the final day of the waiting period or change. Termination of coverage will be on the last day employee worked or was part of an eligible class.  
 first day of the insurance month coinciding with or next following the final day of the waiting period or change. Termination of coverage will be the last day of the insurance month in which the employee worked or was part of an eligible class.

**Employer Contribution**

Complete this table listing the percentage of premium the employer pays.

	Vision	Short term disability (STD)*	Long term disability (LTD)*	Basic term life	Voluntary term life	Medical	Dental
Employee	_____ %	_____ %	_____ %	_____ %	_____ %	_____ %	<u>0</u> %
Dependent	_____ %	N/A	N/A	_____ %	_____ %	_____ %	<u>0</u> %
Retired	N/A	N/A	N/A	_____ %	N/A	_____ %	<u>N/A</u> %
Other _____							

Are you requesting to insure retirees?  yes  no If yes, list coverages: \_\_\_\_\_

If yes,  current retirees  future retirees  other \_\_\_\_\_

Note: Medical requires 51+ enrolled lives for retired coverage. Medical, life and dental are subject to Underwriting approval, and vision and disability are not available for retirees.

**Definition of Compensation (Salary-Based Benefits) – Definition of compensation for owners is automatically included in all life and disability policies.** 210

- |   |   |
|---|---|
| <input type="checkbox"/> base wage (excludes bonus, commission, overtime, etc.)<br><input type="checkbox"/> base wage (with bonus)<br><input type="checkbox"/> base wage (with commission)<br><input type="checkbox"/> base wage (with commission and bonus)<br><input type="checkbox"/> if different by class (please specify) _____ | <input type="checkbox"/> W-2 (1 year average)<br><input type="checkbox"/> W-2 (2 year average)<br><input type="checkbox"/> W-2 (3 year average)<br><input type="checkbox"/> contract salary |
|---|---|

**Employee Eligibility**

- standard - An employee must work at least 30 hours per week to be eligible for insurance.
- other (select between 20 and 40 hours): 20 (not offered to groups subject to small employer legislation)

**Ineligible Employees**

- An independent contractor/1099 (unless required by law)
- An employee who works less than the required number of hours per week, or is employed as a temporary or seasonal employee, is not eligible for insurance.
- Employees residing or working in Hawaii (for medical coverage)

How many employees are on your payroll? <b>60,000</b>	How many employees are eligible (based on hours worked per week)? <b>50,000</b>
--	--

Describe any excluded class of employees or location  
**Any one working under 20 hours a week**

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.

**Complete the following sections for coverages being requested.**

**Disability**

If you are requesting short term disability coverage, are there employees working in any of the states listed below (policies offered in these states are supplemental coverage only; they are not intended to provide coverage as outlined by each state)?  yes  no

If yes, indicate the number of employees for each state in the box.

California	Hawaii	New Jersey	New York	Rhode Island
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**Life/Disability**

If requesting life or disability insurance, are there any employees not actively at work or dependents in a period of limited activity (if dependent life insurance is requested)?  yes  no If yes, please list employees and dependents not actively at work, reason not actively at work, their last day worked and expected return to work date

**Dental**

If you are replacing dental insurance, did your prior dental coverage include benefits for orthodontia treatment?  yes  no  
 Did your prior coverage include a dental maximum accumulation (max rollover, max builder)?  yes  no  
 If yes, please provide a copy of the prior carrier report showing individual maximums with roll over amounts.

Medical

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Do you offer medical coverage to your employees through another carrier (not including insurance coverage that is being replaced)?  yes  no If yes, number of covered employees? \_\_\_\_\_

Is any employee presently not performing his/her duties on a full time basis due to an illness or injury?

yes  no If yes, explain: \_\_\_\_\_

Employer Group Size for Medical (this information is in reference to Medicare status)

Companies that are affiliated or file a combined tax return must be considered one employer. Count the employees of all affiliated companies and units when answering the following questions.

#1. Did you have 20 or more (full-time, part-time, seasonal, or partners) total employees for each working day in each of 20 or more calendar weeks in the current or preceding year?  yes  no If yes, you must also answer question #2. If no, skip question #2.

#2. Did you have 100 or more (full-time, part-time, seasonal, or partners) total employees on 50 percent or more of your business days during the previous calendar year?  yes  no

If 20 or 100 employees is reached mid-year, as of what date did you have 20 or 100 employees for the number of weeks required in the definition above? \_\_\_\_\_

Medical/Dental/Vision

COBRA eligibility is defined as employers who employed 20 or more full and full-time equivalent or part-time employees on at least 50% of the working days in the prior calendar year. Do you meet the eligibility definition?  yes  no

If COBRA applies, please select desired billing option:  group bill policyholder  direct bill continuee (individual)

If you currently have anyone on COBRA, please submit enrollment form with qualifying event date noted and reason for COBRA

All Coverages

Employer elects to be:

standard accounting (Principal Life generates a monthly premium statement listing coverage(s) and premium for each member.)

self accounting - not available for medical coverage and prior approval required (Employer submits a monthly billing report to Principal Life listing member, member volume, premium and number of covered members.)

ERISA plan number: 501 Coverage: Dental

ERISA plan number: \_\_\_\_\_ Coverage: \_\_\_\_\_

If more, attach list with ERISA plan number and coverage.

Plan administrator: Dillard's, Inc

Plan sponsor: Same

Agent for legal services: same

Ending date of plan's fiscal year: May 31st

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 and the Named Fiduciary is other than the employer, fill in the information below. Principal Life may not be designated as Named Fiduciary.

The "Named Fiduciary" shall be: \_\_\_\_\_

Designation as Named Fiduciary is accepted. (Required only if the "Named Fiduciary" is an individual.)

By [Signature]

Title Asst Risk Manager

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 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. If this application is accepted, all group policies will be combined and treated as one policy for the purpose of determining any experience premium refund. 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 medical and long term disability insurance have been explained to and understood by the employer. Actively at work and period of limited activity for life 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.
- 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, Options 4, 2, 2 for further details on your case. We have placed a more detailed description of our compensation programs on [www.principal.com/groupcompensation](http://www.principal.com/groupcompensation).
- 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.

**NOTE:** If Principal Life determines, due to requirements of law or because of our own underwriting criteria, to issue our group insurance through a multiple-employer group insurance trust, the employer hereby subscribes to and agrees to the terms of that trust

**Agreement and Signatures (continued)**

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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. Fraud or misrepresentation may be grounds for nonrenewal or termination under the terms of the group policy.

Employer (company name)

**Dillard's, Inc.** *Dillard's Flex Benefit Plan*

Signed by (must be an officer)

Officer's title

Date signed

Licensed resident agent(s) (individual/firm)

Agent's license number

Date signed

Signature of soliciting agent(s) (If more than one, all must sign)

Date signed

**For Principal Life Use Only**



**Principal Life  
Insurance Company**

September 23, 2010

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

RE Group Term Life Insurance  
Policy Forms - GC 7006 DIL  
Booklet Certificate Form – GH 1003 DIL  
Principal Life Insurance Company  
NAIC No. 61271-332  
FEIN # 42-0127290

Attached for your review and approval are 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. The changes are italicized and in red font on the attached policy and booklet certificate insert pages for your ease in reviewing. These are new forms and are not replacing any forms previously approved.

If approved, these pages will be used for this one case only, with our Group Dental Insurance Policy forms series GC 7000, et al, and GH 1000, et al, which were originally filed and approved in your state on July 2, 2003, with subsequent revisions also filed and approved.

This policyholder has also requested use of the enclosed enrollment form GP 45697-6 specific to their group.

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](mailto:mccoy.ann@principal.com)