

SERFF Tracking Number: PRLF-126736744 State: Arkansas  
Filing Company: Principal Life Insurance Company State Tracking Number: 46556  
Company Tracking Number:  
TOI: H16G Group Health - Major Medical Sub-TOI: H16G.001C Any Size Group - Other  
Product Name: PPACA Filing  
Project Name/Number: /

## Filing at a Glance

Company: Principal Life Insurance Company

Product Name: PPACA Filing

TOI: H16G Group Health - Major Medical

Sub-TOI: H16G.001C Any Size Group - Other

Filing Type: Form

SERFF Tr Num: PRLF-126736744 State: Arkansas

SERFF Status: Closed-Approved-  
Closed State Tr Num: 46556

Co Tr Num:

Authors: Bonnie Blue, Donna  
Burns, Dorothy Mcgrean, Brenda  
Mcleran, Ann McCoy

Date Submitted: 08/19/2010

State Status: Approved-Closed

Reviewer(s): Rosalind Minor

Disposition Date: 09/01/2010

Disposition Status: Approved-  
Closed

Implementation Date:

Implementation Date Requested: On Approval

State Filing Description:

## General Information

Project Name:

Project Number:

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Filing Status Changed: 09/01/2010

Status of Filing in Domicile: Pending

Date Approved in Domicile:

Domicile Status Comments:

Market Type: Group

Group Market Size: Small and Large

Group Market Type: Employer, Association

Explanation for Other Group Market Type:

State Status Changed: 09/01/2010

Created By: Dorothy Mcgrean

Corresponding Filing Tracking Number:

Deemer Date:

Submitted By: Dorothy Mcgrean

PPACA: Non-Grandfathered Immed Mkt Reforms

Filing Description:

RE Federal Patient Protection and Affordability Act of 2010 (PPACA)

Policy Amendment: GC 801 PPACA

Booklet-Certificate Rider: GH 198 PPACA

Application Forms – GP45697-08; GP59181 and GP56390-01

Principal Life Insurance Company NAIC No. 61271-332

FEIN # 42-0127290

SERFF Tracking Number: PRLF-126736744 State: Arkansas  
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The above referenced Policy Amendment[s] and Booklet-Certificate Rider[s] are enclosed for your review and approval to comply with the Federal Patient Protection and Affordability Act of 2010. These forms will be for use with our Group Medical Expense Insurance Policy series, GC 5000, et al and the corresponding booklet-certificate series GH 100 A, et al which were originally filed and approved by your department on November 24, 1997, with subsequent revisions also filed and approved. These forms have been filed in our domicile state of Iowa on July 23, 2010 and as of this date are still pending.

Also enclosed are new Application Forms to be used with employer groups subject to PPACA:

- GP45697-08 – Employer Application for Group Medical Insurance
- GP59181 – Enrollment Form with Health Questions
- GP56390-01– Enrollment Form template with Health Questions

To assist in your review of this filing, we are attaching the following:

- A Form Listing which indicates the form numbers of the forms which will require changes to comply with PPACA.
- An Addendum A which explains changes made to the Application forms included with this filing;
- A Statement of Variability for the variables used and ranges where applicable.

All required certification forms are also enclosed. We are also sending the filing fee of \$100.00 via EFT. Please feel free to call me if you have any questions on the attached materials.

## Company and Contact

### Filing Contact Information

Dorothy McGrean, State/Federal Compliance Analyst  
mcrean.dorothy@principal.com  
711 High St.  
K-005-E81  
Des Moines, IA 50392-0002  
800-986-3343 [Phone] 82835 [Ext]  
515-246-2491 [FAX]

### Filing Company Information

Principal Life Insurance Company  
711 High Street  
Des Moines, IA 50392-0002  
CoCode: 61271  
Group Code: 332  
Group Name:  
State of Domicile: Iowa  
Company Type: Life & Health  
State ID Number:

SERFF Tracking Number: PRLF-126736744 State: Arkansas  
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 Product Name: PPACA Filing  
 Project Name/Number: /  
 (800) 986-3343 ext. [Phone] FEIN Number: 42-0127290

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**Filing Fees**

Fee Required? Yes  
 Fee Amount: \$100.00  
 Retaliatory? No  
 Fee Explanation: Per Arkansas Fee Schedule: Filing/review of each Life and/or Accident and Health certificate, rider, application, or endorsement, if filed separately from basic form, per insurer, each form \$ 20  
 5 forms x \$20 each = \$100.00  
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Principal Life Insurance Company	\$100.00	08/19/2010	38892369
Principal Life Insurance Company	\$150.00	09/01/2010	39157390

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 Product Name: PPACA Filing  
 Project Name/Number: /

## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	09/01/2010	09/01/2010

### Objection Letters and Response Letters

Objection Letters				Response Letters		
Status	Created By	Created On	Date Submitted	Responded By	Created On	Date Submitted
Pending Industry Response	Rosalind Minor	08/31/2010	08/31/2010	Dorthy Mcgrean	09/01/2010	09/01/2010

SERFF Tracking Number: PRLF-126736744 State: Arkansas  
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## Disposition

Disposition Date: 09/01/2010

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: PRLF-126736744 State: Arkansas  
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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	PPACA Uniform Compliance Summary	Approved-Closed	Yes
Supporting Document	Additional Supporting Documentation	Approved-Closed	Yes
Form	Policy Amendment	Approved-Closed	Yes
Form	Booklet-Certificate Rider	Approved-Closed	Yes
Form	Employer Application for Group Insurance	Approved-Closed	Yes
Form	Employee Enrollment and Waiver Form (with health questions)	Approved-Closed	Yes
Form	Employee Enrollment and Waiver form template (with health questions)	Approved-Closed	Yes

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Product Name: PPACA Filing  
Project Name/Number: /

## Objection Letter

Objection Letter Status Pending Industry Response

Objection Letter Date 08/31/2010

Submitted Date 08/31/2010

Respond By Date

Dear Dorothy McGrean,

This will acknowledge receipt of the captioned filing.

### Objection 1

- Policy Amendment, GC 801 PPACA (Form)
- Booklet-Certificate Rider, GH 198 PPACA (Form)
- Employer Application for Group Insurance, GP45697-08 (Form)
- Employee Enrollment and Waiver Form (with health questions), GP59181 (Form)
- Employee Enrollment and Waiver form template (with health questions), GP56390-01 (Form)

### Comment:

Our filing fees under Rule and Regulation 57 has been updated. Please review the General Instructions for ArkansasLH or Rule and Regulation 57.

The fee for this submission is \$50.00 per form for a total of \$250.00. Please submit an additional \$150.00 for this submission.

We will begin our review of this submission upon receipt of the additional filing fee.

Please feel free to contact me if you have questions.

Sincerely,

Rosalind Minor

SERFF Tracking Number: PRLF-126736744 State: Arkansas  
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Product Name: PPACA Filing  
Project Name/Number: /

## Response Letter

Response Letter Status Submitted to State  
Response Letter Date 09/01/2010  
Submitted Date 09/01/2010

Dear Rosalind Minor,

### Comments:

I apologize for not sending the correct filing fee. I have added the additional \$150.00 via EFT. Thank you for your review of this filing.

### Response 1

Comments: We have sent the additional fee via EFT

### Related Objection 1

Applies To:

- Policy Amendment, GC 801 PPACA (Form)
- Booklet-Certificate Rider, GH 198 PPACA (Form)
- Employer Application for Group Insurance, GP45697-08 (Form)
- Employee Enrollment and Waiver Form (with health questions), GP59181 (Form)
- Employee Enrollment and Waiver form template (with health questions), GP56390-01 (Form)

Comment:

Our filing fees under Rule and Regulation 57 has been updated. Please review the General Instructions for ArkansasLH or Rule and Regulation 57.

The fee for this submission is \$50.00 per form for a total of \$250.00. Please submit an additional \$150.00 for this submission.

We will begin our review of this submission upon receipt of the additional filing fee.

### Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

*SERFF Tracking Number:*      *PRLF-126736744*                      *State:*                      *Arkansas*  
*Filing Company:*              *Principal Life Insurance Company*              *State Tracking Number:*      *46556*  
*Company Tracking Number:*  
*TOI:*                      *H16G Group Health - Major Medical*              *Sub-TOI:*                      *H16G.001C Any Size Group - Other*  
*Product Name:*              *PPACA Filing*  
*Project Name/Number:*      /

No Rate/Rule Schedule items changed.

We look forward to your approval of our filing.

Sincerely,

Ann McCoy, Bonnie Blue, Brenda Mcleran, Donna Burns, Dorthy Mcgrean

SERFF Tracking Number: PRLF-126736744 State: Arkansas  
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 Product Name: PPACA Filing  
 Project Name/Number: /

## Form Schedule

### Lead Form Number: GC 801 PPACA

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 09/01/2010	GC 801 PPACA	Policy/Cont ract/Fratern al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Policy Amendment	Initial		0.000	GC 801 PPACA.pdf
Approved-Closed 09/01/2010	GH 198 PPACA	Certificate Amendmen t, Insert Page, Endorseme nt or Rider	Booklet-Certificate Rider	Initial		0.000	GH 198 PPACA.pdf
Approved-Closed 09/01/2010	GP45697- 08	Application/ Enrollment Form	Employer Application for Group Insurance	Revised	Replaced Form #: GP45697-07 Previous Filing #:	0.000	GP45697- 08.pdf
Approved-Closed 09/01/2010	GP59181	Application/ Enrollment Form	Employee Enrollment and Waiver Form (with health questions)	Initial		0.000	GP59181.pdf
Approved-Closed 09/01/2010	GP56390- 01	Application/ Enrollment Form	Employee Enrollment and Waiver form template (with health questions)	Revised	Replaced Form #: GP56390 Previous Filing #:	0.000	GP56390- 01.pdf

**PATIENT PROTECTION AND AFFORDABLE CARE ACT OF 2010  
POLICY AMENDMENT TO BE ATTACHED TO AND MADE A PART OF  
PRINCIPAL LIFE INSURANCE COMPANY GROUP POLICY NO. [GME 99999]  
ISSUED TO**

[JOHN DOE COMPANY]

The above Group Policy is hereby amended as follows:

Effective [September 23, 2010,] some of the benefits, terms, conditions, limitations, and exclusions contained in the above Group Policy will change as a result of the Patient Protection and Affordable Care Act of 2010. Except as specifically provided herein, this Policy Amendment is subject to all of the terms, provisions, definitions, and limitations of the above Group Policy. In the event of a conflict between the provisions of any other section of the above Group Policy and the provisions of this Amendment, the provisions of this Amendment shall prevail.

The Group Policy to which this Amendment is attached is amended as stated below.

**A. Definitions:** The following Definitions will be added to PART I – Definitions of the above Group Policy:

**“Emergency Medical Condition (Medical Emergency)”** means a medical condition which manifests itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- (1) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; or
- (2) serious impairment to bodily functions; or
- (3) serious dysfunction of any bodily organ or part.

**“Emergency Services”** means with respect to an Emergency Medical Condition: transportation services, including but not limited to ambulance services, and covered inpatient and outpatient hospital services furnished by a provider qualified to furnish those services that are needed to evaluate or stabilize an Emergency Medical Condition.

**“Stabilize”** means, with respect to an Emergency Medical Condition, to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility.

**For the purpose of this Amendment “Essential health benefits”** means benefits covered under the above Group Policy, in at least the following categories: ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance abuse disorder services, including behavioral health treatment, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management and pediatric services, including pediatric oral and vision care. Such benefits shall be consistent with those set forth under the Patient Protection and Affordable Care Act of 2010 and any regulations issued pursuant thereto.

#### **B. Lifetime Dollar Limits**

Essential health benefits, provided within the above Group Policy as shown under PART IV – Benefits, Sections A – General Provisions except for services provided in Section [A][B] (4) – Mental Health, Behavioral, Alcohol or Drug Abuse Treatment Services; Section [A][B](5) - Transplant Services; Section [A][B] (13) - Prosthetics and Section [A][B] (14) - Hospice Care will no longer be subject to lifetime dollar maximum(s).

#### **C. Annual Dollar Limits**

Essential health benefits, provided within the above Group Policy as shown under PART IV – Benefits, Sections A – General Provisions except for services provided in Section [A][B] (4) – Mental Health, Behavioral, Alcohol or Drug Abuse Treatment Services; Section [A][B] (8) – Rehabilitative Services and Section [A][B] (12) – Durable Medical Equipment will no longer be subject to annual dollar maximum(s).

#### **D. Rescissions**

The Principal may not terminate coverage for an insured Member under the above Group Policy based on a misrepresentation by the Member unless the Member has performed an act or practice that constitutes fraud; or made an intentional misrepresentation of material fact as prohibited by the terms of the above Group Policy.

The above Group Policy complies with this provision which can be found under PART II – Policy Administration, Section A – Contract and PART II – Policy Administration, Section C – Policy Termination.

## **E. Preventive Health Services**

[1][1A]

This information replaces the current text listed in the above Group Policy for Pediatric Vaccines, Well Child Visits, Adult Wellness, Mammograms and Colonoscopies [received from a Preferred Provider] under PART IV – Benefits, Section A – General Provisions; Section [A][B] (3) - Covered Charges; and Section [A][B](7) – Wellness. The following services will now be covered without regard to any deductible, [copayment], coinsurance or annual and lifetime maximum requirement that would otherwise apply:

- (1) evidence-based items or services that have in effect a rating of “A” or “B” in the current recommendations of the United States Preventive Services Task Force; or
- (2) immunizations that are recommended from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the insured person involved; or
- (3) preventive care and screenings for infants, children, and adolescents, according to guidelines supported by the Health Resources and Services Administration; or
- (4) in addition to the benefits or services listed under item (1) above, additional preventative care and screening for women according to the guidelines supported by the Health Resources and Services Administration.

[6]

[Benefits for the services included in (1) through (4) above provided by a Non-[Preferred][Network] Provider will be covered as follows:

- a. Adult Wellness and Colonoscopy – Not Covered
- b. Well Child, Pediatric Immunizations and Mammograms – Non-[Preferred][Network] deductible and coinsurance.]

Any other services included in the Wellness section not listed above will be covered the same as any other service based on location of service.]

[7]

[Benefits for the services included in (1) through (4) above will be covered as follows  
- 100%; no copays or deductibles apply

Any other services included in the Wellness section not listed above will be covered the same as any other service based on location of service. ]

## **F. Extension of Coverage to Dependents**

The following Definition will replace the current definition of Dependent Child in PART I – Definitions in the above Group Policy:

### **[Dependent Child; Dependent Children**

- [2] a. A Member's natural, stepchild or legally adopted child, if that child is less than [26] years of age.

A newly adopted child will be considered a Dependent Child from the date of Placement with the Member for the purpose of adoption or the date of adoption, whichever is earlier. The child will continue to be a Dependent Child unless the Placement is disrupted prior to legal adoption and the child is removed from Placement.

- b. A Member's foster child, provided:

- (1) the child is less than [26] years of age; and
- (2) the child has been placed with the Member or spouse insured under this Group Policy by an authorized state placement agency or by order of a court; and
- (3) the required documentation has been provided and the child is approved in Writing by The Principal as a Dependent Child.

- [3] [c. A Member's child [26] years but less than [30] years of age who otherwise qualifies under a. and b. above, if that child receives principal support from the Member and is a Full-Time Student, as defined in this PART I.]

- [4] [d. A Domestic Partner's child who otherwise qualifies under a. [or b.] above or if the Member or Domestic Partner has been appointed the child's guardian under a valid court order.]

Dependent Child will include any child covered under a Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN) as defined by applicable federal law and state insurance laws that are applicable to this Group Policy, provided the child meets this Group Policy's definition of a Dependent Child.]

## **G. Right to Appeal**

[5]

A Member has the right to appeal any decision or action taken by The Principal to deny, reduce, or terminate the provision of or payment for health care services covered by the above Group Policy. The above Group Policy already provides right to appeal procedures which can be found under PART IV – Benefits, [B1 (1)] [B1 (1A)] – Utilization Management Program and PART IV – Benefits, Section C – Claim Procedures. These provisions must first be exhausted before a right to an external independent review can be granted. When The Principal has denied, reduced, or terminated a requested service or payment for the service based on a judgment as to the medical necessity, appropriateness, health care setting, level of

care, or effectiveness of the health care service, the Member has the right to have that decision reviewed by an independent review organization not associated with The Principal.

Except where a covered person's life or health would be seriously jeopardized, a Member must first exhaust the internal review process set forth within the above Group Policy before The Principal will grant for an external independent review. A Member, or Dependent or a designated representative or provider acting on behalf of the Member or Dependent has the right to apply to the Insurance Commissioner for an external review of an adverse determination or final adverse determination which involves an issue of medical necessity, appropriateness, health care setting, level of care or effectiveness.

A Member must authorize the release of any medical records necessary to complete the External Review.

#### **H. Emergency Services**

[This information replaces the current text we have under PART IV – Benefits, Section A (6) – Medical Emergency.]

- [6] Emergency Services will be covered without the need for any prior authorization determination and without regard as to whether the health care provider furnishing such services is a Participating Provider. Emergency Services provided by a Non-participating Provider will be covered the same as if the services were provided by a Participating Provider.

The Group Policy does not currently require authorizations for Emergency Services nor do we apply more restrictive requirements to Non-participating Providers for Emergency Services.]

- [7] [Emergency Services will be covered without the need for any prior authorization determination.]

#### **I. Direct Access to Obstetricians and Gynecologists**

A female insured person or Dependent may see any available participating health care professional who specializes in obstetrics or gynecology without referral from her primary care provider.

The above Group Policy does not currently require a primary care provider.

**J. Selection of a Primary Care Provider**

A Member or Dependent may designate any available participating primary care provider who is available to accept him or her as their primary care provider.

The above Group Policy does not currently require a primary care provider.

**K. Preexisting Condition Limitations**

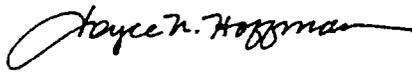
The Preexisting Condition Exclusion provision described under this Group Policy, PART IV - Benefits, Section E, will not apply to a Member or Dependent who is under 19 years of age. As of the effective date of this Amendment, with respect to a Member, or Dependent who is under 19 years of age, the above Group Policy will cover any covered Treatment or Service that may have been previously excluded by name or specific description.

This Amendment will take effect upon the first renewal of the above Group Policy following September 23, 2010. This Amendment terminates concurrently with the above Group Policy to which it is attached.

All other terms, provisions, conditions, limitations, and exclusions of the Group Policy remain in full force and effect with respect to benefits and all other aspects of the insurance of the Group Policy, and are controlling with respect to this Amendment unless expressly modified herein.

Nothing in this Amendment will vary, alter, or extend any provision or condition of the Group Policy other than as stated in this Amendment.

**PRINCIPAL LIFE INSURANCE COMPANY**

 Senior Vice President and Corporate Secretary	 President and Chief Executive Officer
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**PATIENT PROTECTION AND AFFORDABLE CARE ACT OF 2010  
BOOKLET-CERTIFICATE RIDER**

For Group Policy No. [GME\_\_\_\_\_]  
[JOHN DOE COMPANY]

Effective [September 23, 2010] some of the benefits, terms, conditions, limitations, and exclusions contained in this Rider will change as a result of the Patient Protection and Affordable Care Act of 2010. Except as specifically provided herein, this Rider is subject to all of the terms, provisions, definitions, and limitations of the above Group Policy. In the event of a conflict between the provisions of any other section of the above Group Policy and the provisions of this Rider, the provisions of this Rider shall prevail.

**A. Definitions:** The following Definitions will be added to your Booklet-Certificate:

**“Emergency Medical Condition (Medical Emergency)”** means a medical condition which manifests itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- (1) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; or
- (2) serious impairment to bodily functions; or
- (3) serious dysfunction of any bodily organ or part.

**“Emergency Services”** means with respect to an Emergency Medical Condition: transportation services, including but not limited to ambulance services, and covered inpatient and outpatient hospital services furnished by a provider qualified to furnish those services that are needed to evaluate or stabilize an Emergency Medical Condition.

**“Stabilize”** means, with respect to an Emergency Medical Condition, to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility.

**For the purpose of this Rider “Essential health benefits”** means benefits covered under the attached Booklet-Certificate, in at least the following categories: ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance abuse disorder services, including behavioral health treatment, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management and pediatric services, including pediatric oral and vision care. Such

benefits shall be consistent with those set forth under the Patient Protection and Affordable Care Act of 2010 and any regulations issued pursuant thereto.

### **B. Lifetime Dollar Limits**

Essential health benefits, provided within the attached Booklet-Certificate as shown under General Provisions[, except for services provided for in Mental Health, Behavioral, Alcohol or Drug Abuse Treatment Services; Transplant Services; Prosthetics and Hospice Care will no longer be subject to lifetime dollar maximum(s). See item E. Preventive Health Services below for a summary of these changes.

### **C. Annual Dollar Limits**

Essential health benefits, provided within the attached Booklet-Certificate as shown under General Provisions[, except for services provided for in Mental Health, Behavioral, Alcohol or Drug Abuse Treatment Services; Rehabilitative Services and Durable Medical Equipment will no longer be subject to annual dollar maximum(s). See item E. Preventive Health Services below for a summary of these changes.

### **D. Rescissions**

We may not terminate your coverage under the attached Booklet-Certificate based on a misrepresentation by you unless you have performed an act or practice that constitutes fraud; or made an intentional misrepresentation of material fact as prohibited by the terms of the Booklet-Certificate.

This is addressed in your Booklet-Certificate under How to be Insured – Members, Member Expense Insurance

### **E. Preventive Health Services**

[1][1A]

This information replaces the current text in the attached Booklet-Certificate for Pediatric Vaccines, Well Child Visits, Adult Wellness, Mammograms and Colonoscopies, under General Provisions; Covered Charges and Wellness. The following services will now be covered without regard to any deductible, [copayment], coinsurance or annual and lifetime maximum requirement that would otherwise apply:

- (1) evidence-based items or services that have in effect a rating of “A” or “B” in the current recommendations of the United States Preventive Services Task Force; or
- (2) immunizations that are recommended from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the insured person involved; or
- (3) preventive care and screenings for infants, children, and adolescents, according to guidelines supported by the Health Resources and Services Administration; or

- (4) in addition to the benefits or services listed under item (1) above, additional preventative care and screening for women according to the guidelines supported by the Health Resources and Services Administration.

The following Benefits will replace the current Benefits described under Medical Care Covered Charges, Benefits Payable for Pediatric Vaccines, Well Child Visits, Adult Wellness, Mammograms and Colonoscopies and will be payable as shown below:

- [6] [Benefits for the services included in (1) through (4) above will be covered as follows
- Provided by a [Preferred][Network] provider
- [1A]
- 100%; no [copays] or deductibles apply
  - Provided by a Non-[Preferred][Network] provider
    - Adult Wellness and Colonoscopy – Not Covered
    - Well Child, Pediatric Immunizations and Mammograms – Non-[Preferred][Network] deductible and coinsurance.]

Any other services included in the Wellness section not listed above will be covered the same as any other service based on location of service. ]

- [7] [Benefits for the services included in (1) through (4) above will be covered as follows
- 100%; no copays or deductibles apply

Any other services included in the Wellness section not listed above will be covered the same as any other service based on location of service. ]

#### **F. Extension of Coverage to Dependents**

The following Definition will replace the current definition of Dependent Child in the Definitions section in the attached booklet-certificate:

**[Dependent Child; Dependent Children** means:

- [2]
- Your natural, stepchild or legally adopted child, if that child is than [26] years of age.

A newly adopted child will be considered a Dependent Child from the date of Placement with you for the purpose of adoption or the date of adoption, whichever is earlier. The child will continue to be a Dependent Child unless the Placement is disrupted prior to legal adoption and the child is removed from Placement.

- Your foster child, provided:
  - the child is less than [26] years of age; and
  - the child has been placed with you or your spouse insured under this Booklet Certificate by an authorized state placement agency or by order of a court; and
  - the required documentation has been provided and the child is approved in

Writing by Us as a Dependent Child.

- [3] [- Your child [26] years but less than [30] years of age who otherwise qualifies above, if that child receives principal support from you and is a Full-Time Student, as defined.]
- [4] [- Your Domestic Partner's child who otherwise qualifies above, or if you or your Domestic Partner has been appointed the child's guardian under a valid court order.]

Dependent Child will include any child covered under a Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN) as defined by applicable federal law and state insurance laws that are applicable to the Group Policy, provided the child meets the definition of a Dependent Child.]

**G. Right to Appeal**

[5]

You have the right to appeal any decision or action taken by Us to deny, reduce, or terminate the provision of or payment for health care services covered by the attached Booklet-Certificate. Your Booklet-Certificate already provides right to appeal procedures which can be found under the Utilization Management Program and Claim Procedures provisions. These provisions must first be exhausted before a right to an external independent review can be granted. When We have denied, reduced, or terminated a requested service or payment for the service based on a judgment as to the medical necessity, appropriateness, health care setting, level of care, or effectiveness of the health care service, you have the right to have Our decision reviewed by an independent review organization not associated with Us.

Except where a covered person's life or health would be seriously jeopardized, you must first exhaust the internal review process set forth within the attached Booklet-Certificate before We will grant for an external independent review. You, your Dependent or a designated representative or provider acting on behalf of you or your Dependent have the right to apply to the Insurance Commissioner for an external review of an adverse determination or final adverse determination which involves an issue of medical necessity, appropriateness, health care setting, level of care or effectiveness.

You or your Dependent must authorize the release of any medical records necessary to complete the External Review.

## **H. Emergency Services**

[This information replaces the current text we have under Medical Emergency section.]

- [6] [Emergency Services will be covered without the need for any prior authorization determination and without regard as to whether the health care provider furnishing such services is a Participating Provider. Emergency Services provided by a Non-participating Provider will be covered the same as if the services were provided by a Participating Provider.

[Your Booklet-Certificate does not currently require authorizations for Emergency Services nor do we apply more restrictive requirements to Non-participating Providers for Emergency Services.]

- [7] [Emergency Services will be covered without the need for any prior authorization determination.]

## **I. Direct Access to Obstetricians and Gynecologists**

A female insured person or Dependent may see any available participating health care professional who specializes in obstetrics or gynecology without referral from her primary care provider.

The attached Booklet-Certificate does not currently require a primary care provider.

## **J. Selection of a Primary Care Provider**

A Member or Dependent may designate any available participating primary care provider who is available to accept him or her as their primary care provider.

The attached Booklet-Certificate does not currently require a primary care provider.

## **K. Preexisting Condition Limitations**

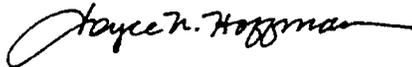
The Preexisting Condition Exclusion provision described under the attached Booklet-Certificate, will not apply to you or your Dependent who are under 19 years of age. As of the effective date of this Rider, with respect to You or your Dependent who are under 19 years of age, your benefits will cover any covered Treatment or Service that may have been previously excluded by name or specific description.

This Rider will take effect upon renewal of the above Group Policy. This Rider terminates concurrently with the above Group Policy to which it is attached.

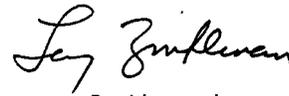
All other terms, provisions, conditions, limitations, and exclusions of the Group Policy remain in full force and effect with respect to benefits and all other aspects of the insurance of the Group Policy, and are controlling with respect to this Rider unless expressly modified herein.

Nothing in this Rider will vary, alter, or extend any provision or condition of the Group Policy(ies) other than as stated in this Rider.

**PRINCIPAL LIFE INSURANCE COMPANY**



Senior Vice President and  
Corporate Secretary



President and  
Chief Executive Officer



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: new case amendment (only complete sections with changes) Account number

Requested effective date: Advance premium received \$

Employer Information

Legal name of company

DBA name (if applicable)

C-corporation S-corporation limited liability company partnership sole proprietorship other

Physical street address City State ZIP code

Billing/mailling address (P.O. box) City State ZIP code

Group contact name Telephone number FAX number E-mail address

Billing contact name (if different) Nature of business and SIC code Federal tax ID number Date company established

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

If yes, when and under what name?

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 no If yes, attach an explanation.

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

Have you elected a Health Savings Account with Principal Life? yes 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

Employers with Multiple Locations or Participating Units

Does your business have more than one physical location? yes no If yes, list with complete addresses:

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

Are multiple bills requested? yes 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 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 unit/exclude unit, Number of employees

Do you agree with all the benefit plan provisions that you are applying for as outlined in your proposal # \_\_\_\_\_ and version number \_\_\_\_?      yes      no      \_\_\_\_\_ Initials of person signing this form for the employer on page 6.

Dental/vision/medical: Do you want insurance for:      employees only      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) \_\_\_\_\_

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

What waiting period should apply to Employees hired on or **PRIOR** to the effective date of the case/coverage?      none      \_\_\_\_\_ days      \_\_\_\_\_ months

What waiting period should apply to Employees hired **AFTER** the effective date of the case/coverage?      none      \_\_\_\_\_ days      \_\_\_\_\_ months

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	_____ %	_____ %	_____ %	_____ %	_____ %	_____ %	_____ %
Dependent	_____ %	N/A	N/A	_____ %	_____ %	_____ %	_____ %
Retired	N/A	N/A	N/A	_____ %	N/A	_____ %	_____ %
Other _____							

Retiree coverage is available for Life, Medical and Dental but requires underwriting approval. Note: Life and Medical requires 51+ enrolled lives for retired coverage. Vision and disability coverages are not available for retirees.

If requesting to insure retirees, please indicate which coverage(s)?      life      medical      dental

Are you requesting coverage for:      current retirees      future retirees?

If requesting retiree coverage, list the definition of Retiree (example: 10 years of service at least 55 years of age):

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

base wage (excludes bonus, commission, overtime, etc.)	W-2 (1 year average)
base wage (with bonus)	W-2 (2 year average)
base wage (with commission)	W-2 (3 year average)
base wage (with commission and bonus)	contract salary
if different by class (please specify) _____	

If commissions or bonuses are included:      1 year average                      2 year average                      3 year average

**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): \_\_\_\_\_ (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? _____	How many employees are eligible (based on hours worked per week)? _____
---	---

Describe any excluded class of employees or location \_\_\_\_\_

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.

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**

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.

**These questions are in reference to Medicare status**

#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? \_\_\_\_\_

**These questions are in reference to Mental Health benefits**

Did you employ an average of 51 or more full-time equivalent employees on business days during the preceding calendar year?    yes    no

The average number of full-time equivalent employees is calculated by adding:

- (a) the number of full-time employees you employed for the entire calendar year; PLUS
- (b) the total number of hours worked by all part-time employees and all full-time employees who were not employed full-time throughout the entire calendar year, divided by the number of annual hours typically worked by your full-time employees (not to exceed 2,080).
- (c) Round the sum of (a) plus (b) down to the nearest whole number.

**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 your group is COBRA eligible, do you have anyone currently electing COBRA benefits?    yes    no

If yes, please list. \_\_\_\_\_

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: \_\_\_\_\_ Coverage(s): \_\_\_\_\_

ERISA plan number: \_\_\_\_\_ Coverage(s): \_\_\_\_\_

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

Plan administrator: \_\_\_\_\_

Plan sponsor: \_\_\_\_\_

Agent for legal services: \_\_\_\_\_

Ending date of plan's fiscal year: \_\_\_\_\_

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 \_\_\_\_\_

Title \_\_\_\_\_

### Agreement and Signatures

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.
- The employer understands that the insurance policy and certificates of coverage may, at the discretion of Principal Life, be provided to the employer in paper or electronic format. The employer agrees to promptly distribute the certificates of coverage to insured employees at the beginning of their coverage under the group policy and redistribute them from time to time thereafter as reasonably required by Principal Life.
- Your agent or broker cannot change or waive any provision of this application or the policy or policies without the written approval of an officer of Principal Life in the home office.

- As a result of this sale and any subsequent renewal, your broker and marketing organization, if any, may receive commissions, administrative service fees, other compensation including non-cash compensation, and bonuses based on factors such as, volume of new sales, member and case counts, total premium volume, maintaining a certain percentage of business with Principal Life, selling a certain mix of products, and/or the profitability of the business. The cost of this compensation may be directly or indirectly reflected in the premium or fee for the product(s) you have applied for on this application form. This compensation is in addition to any compensation the broker may receive from you. [Contact us at [1-800-388-4793, 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/group/compensation].]
- The person signing this form for the employer has legal authority to bind the employer for whom application is being made.
- The employer agrees to make timely notification of any employee termination, status change, or other material changes that may affect the eligibility of employees or their dependents. Timely notification is no more than 31 days past the actual date of such change.
- The employer understands that failure to pay premium when due will be considered a default in premium payment and coverage will terminate at the end of the grace period. If coverage is terminated for nonpayment of premium, premium through the grace period is due and will be collected. The employer understands that coverage may also be terminated for other reasons as provided in the group policy.
- The employer understands their rights and responsibilities if electing self accounting status.

**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.

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

Employer (company name)

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**



Mailing Address: Des Moines, IA 50392-0002

Principal Life Insurance Company

Employee Enrollment & Waiver - AR

Company name | Division level | Account number/unit number

Employee Information

Your name (last, first, middle initial) | Social security number | Mailing address (street) | Birth date | male | female | (city) | (state) | (ZIP code) | Do you have an eligible spouse or child? | yes | no | Date employed full-time | Hours worked per week | Job occupation/class | Location | Salary amount | Salary mode | yearly | weekly | hourly | monthly | bi-weekly | What is your payroll mode? | monthly | semi-monthly | weekly | bi-weekly | Employer ZIP | Employer county

Benefit Options (You can only elect those coverages offered by your employer.)

Table with columns: Coverage, Employee, Spouse, Children. Rows include Medical, Dental, Vision, Group term life, Voluntary term life (VTL), Supplemental term life, Short term disability (STD), Long term disability (LTD). Includes 'Important!' section for declining coverage.

Nicotine Products

Have you used nicotine products (including cigarette, pipe, cigar or chewing tobacco) in the past 12 months? | yes | no | Has your spouse used nicotine products (including cigarette, pipe, cigar or chewing tobacco) in the past 12 months? | yes | no

Important – Complete Page 1, Page 2, Page 3, Page 4, and Page 5.

**All primary and contingent beneficiaries, whether adults or minors, should be included in the beneficiary designation below.**

**Primary Beneficiaries:**

Name	Percentage	Relationship
Address		Social security number
Name	Percentage	Relationship
Address		Social security number
Name	Percentage	Relationship
Address		Social security number

**Contingent Beneficiaries:**

Name	Percentage	Relationship
Address		Social security number
Name	Percentage	Relationship
Address		Social security number

**Voluntary Term Life Beneficiary Designation** (Complete if covered for voluntary term life coverage. If you want to use the same beneficiary designation as indicated for group term life coverage above, write "same as above" in the beneficiary section below.)

**All primary and contingent beneficiaries, whether adults or minors, should be included in the beneficiary designation below.**

**Primary Beneficiaries:**

Name	Percentage	Relationship
Address		Social security number
Name	Percentage	Relationship
Address		Social security number
Name	Percentage	Relationship
Address		Social security number

**Contingent Beneficiaries:**

Name	Percentage	Relationship
Address		Social security number
Name	Percentage	Relationship
Address		Social security number

The right to make future changes is reserved. If two or more beneficiaries are named, the proceeds shall be paid to the named beneficiaries, or to the survivor or survivors, in equal shares, unless specified otherwise.

If any beneficiary is designated as trustee, it is understood and agreed that Principal Life Insurance Company shall not be a party to nor bound by the conditions of any trust and payment of the net proceeds of said policy on the death of the insured to the then designated beneficiary shall be a complete discharge as to Principal Life.

If you have designated a minor child(ren) as your beneficiary, you must complete the Uniform Transfers to Minors Act form.

NOTE: If you are covered by both group term life and voluntary term life coverage and only indicate a beneficiary designation for one of these, the facility of payment provision in the group policy will be used to determine how proceeds will be paid for the other coverage.

**Eligible Dependent Information** (Complete if you have elected benefits for your spouse or children.)

Spouse's name		Birth date	male	female	Social security number
Name(s) of child(ren)		Birth date	male	female	Social security number
					foster child* disabled or handicapped child**
					foster child* disabled or handicapped child**
					foster child* disabled or handicapped child**

\* If you checked foster child, was the child placed with you by an authorized state placement agency or by order of a court?    yes    no

\*\* When your child, who is developmentally disabled or physically handicapped, reaches/exceeds the maximum age, an Application to Continue Handicapped Child form must be completed and reviewed to determine eligibility.

Is your spouse employed by this company?    yes    no

**Health Information for All Coverages Being Applied for** (Read the Notice of Information Practices prior to answering)

To prevent delays give full details to "yes" answers for everyone electing coverage. If more space is needed, attach a separate page giving full details. Sign and date all pages. 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 anyone planning or scheduled for hospitalization, surgery, medical treatment, therapy, counseling, medical tests or examinations or taking any medicine or is anyone pregnant (due date \_\_\_\_\_) any complications \_\_\_\_\_ C-Section date \_\_\_\_\_ Multiple births?  yes  no )

2.  yes  no In the past five years, has anyone 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 OR been diagnosed or received treatment for any of the following conditions or disorders? (Check ALL that apply.) If a condition is not noted, please list it.

- [cancer]       [alcohol][drug use]       [arthritis][bone][joint][muscle]       [skin][eye][ear][nose][throat]
- [tumor]       [high cholesterol]       [allergy][asthma][respiratory]       [kidney][bladder][urinary]
- [infertility]       [heart][circulatory]       [digestive][intestinal][eating]       [stroke][neurological][nervous system]
- [liver][hepatitis]       [mental][nervous]      high blood pressure [– last reading and date \_\_\_\_ / \_\_\_\_ ]
- [diabetes – last HbA1c reading and date \_\_\_\_ / \_\_\_\_ ]       [organ or other transplants]
- [Acquired Immune Deficiency Syndrome (AIDS)/infection with HIV (Human Immunodeficiency Virus)/other immune disorder]
- [other – including other meds \_\_\_\_\_ ]
- [tobacco use (which applicant: \_\_\_\_\_ )]

Name	Date diagnosed/treated	Length of illness or condition
Diagnosis of illness or condition	Type of treatment	
Any current symptoms or problems		
Names of all medications		

Names and addresses of doctors, hospitals or other providers

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Name	Date diagnosed/treated	Length of illness or condition
Diagnosis of illness or condition	Type of treatment	
Any current symptoms or problems		
Names of all medications		

Names and addresses of doctors, hospitals or other providers

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Name	Date diagnosed/treated	Length of illness or condition
Diagnosis of illness or condition	Type of treatment	
Any current symptoms or problems		
Names of all medications		

Names and addresses of doctors, hospitals or other providers

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Name	Date diagnosed/treated	Length of illness or condition
Diagnosis of illness or condition	Type of treatment	
Any current symptoms or problems		
Names of all medications		

I understand and agree with the following statements:

- My dependents are not eligible for coverages I don't have. My dependents, including step and foster children and any over the maximum age, are eligible based on plan provisions but those over the maximum age will be verified when a claim is filed. I have read and understand the Preexisting Condition Exclusion and the Special Enrollment Rights and know if I refuse medical coverage, I and my dependents must wait for the next open enrollment unless I become eligible during a Special Enrollment. If I refuse dental coverage, I and my dependents may enroll later but this will affect the level of benefits. If I refuse life or disability coverage, I may apply later but I must show proof of good health and coverage will be subject to approval by Principal Life. If I refuse coverage, I cannot enroll after retirement.
- If the group policy does not require my contribution, I cannot decline any coverage unless the policy indicates otherwise.
- If the group policy requires my contribution, I authorize my employer to deduct from my pay.
- I represent all information on this form and attachments is complete and true to the best of my knowledge. They are part of this request for coverage. I agree Principal Life is not liable for a claim before the effective date of coverage and all policy provisions apply. I have read, or had read to me, the information and my answers on this form. During the first two years coverage is in force, fraud or intentional misrepresentations can cause changes in my coverage, including cancellation back to the effective date.
- Any person who, with intent to defraud or knowingly is facilitating a fraud against an insurer, submits an application or files a claim with false or deceptive statements, may be guilty of insurance fraud.
- For life and disability coverages, I authorize any health care provider who has personal information, including physical, mental, drug or alcohol use history, regarding me or a dependent, to give such data to Principal Life agents and employees performing my business transactions. I authorize Principal Life to release data as required by law. If signed in connection with an application, reinstatement or a change in benefits, this form will be valid two years from the date below. I may revoke authorization for information not yet obtained. I understand data obtained will be used by Principal Life for claims administration and determining eligibility for life and disability coverage. Information will not be used for any purposes prohibited by law.
- Explanation of Benefits reflecting claim payments for myself and my dependents will be sent to my home address. I also understand collection of social security numbers for myself and my dependents will be used by Principal Life only as allowed by law.
- For life coverage, I understand that as the employee, the insurance I and my dependents have applied for will begin on the effective date of coverage provided I am at work on that date. If I am not actively at work on such date, subject to the terms of the group policy, coverage may not go into effect until after my return to work. Furthermore, I understand that no insurance may become effective for any member of my family while he/she is in a period of limited activity.
- For medical coverage, I authorize pharmacy benefit managers, "health care providers", and entities covered under the HIPAA Privacy Rule and their agents and employees, to disclose my personal health information to Principal Life, its agents, and employees, for purposes of underwriting my application for coverage, and making eligibility, premium rating, and enrollment decisions, relating to any coverage I have, have applied for, or may in the future apply for with Principal Life or other entities covered under the HIPAA Privacy Rule. This includes information concerning the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection, sexually transmitted diseases, mental illness, and the use of alcohol, drugs, and tobacco. This authorization shall remain in force for two years following the date of my signature. I may revoke this authorization in writing at any time by sending the request for revocation to: Health Information Protection Analyst, Group Compliance, Principal Life Insurance Company, Des Moines, IA 50392-0002. A revocation is not effective if Principal Life has relied on the protected health information disclosed to it. Any information disclosed under this authorization may no longer be covered by privacy provisions of HIPAA and may be subject to redisclosure. I understand that if I refuse this authorization, Principal Life may not make an eligibility determination, and I will not be considered for coverage with Principal Life. I have read and I understand this authorization.

A copy of this form will be as valid as the original.

**I declare** that the information I have completed on this enrollment form is complete and true. I understand an agent or broker cannot guarantee coverage, revise rates, benefits, or provisions without written approval from Principal Life.

Your signature  X  Date signed \_\_\_\_\_

### Instructions

After this form is completed and signed, make two copies and send the original to Principal Life Insurance Company:

- Employer – copy of Pages 1, 2, 3, and 5
- Employee – copy of Pages 1, 2, 3, 4, and 5

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Federal Regulations require an employee to receive the following notices for medical coverage offered in the state of Arkansas.

### **Preexisting Condition Exclusion**

Preexisting Conditions Exclusions apply to individuals covered on the policy issue date of a new group whose prior coverage was 12 months or less; and late enrollees.

A preexisting condition is a condition present before your enrollment date in any new health plan. If you or your dependents received, or were recommended to receive medical advice, diagnosis, care, or treatment for a condition (physical or mental), in the last six months, the preexisting exclusion will apply. This preexisting exclusion period is 12 months and will exclude benefits for any treatment or service during the preexisting condition period.

Late enrollees may not enroll until the next annual open enrollment period at which time the preexisting condition exclusion period will apply. The preexisting exclusion will not apply to pregnancy or to individuals under the age of 19.

The preexisting exclusion period may be reduced by the number of days you or your dependents were covered under a prior health plan. You and your dependents have the right to demonstrate previous coverage by requesting a certificate of coverage from your prior health plan. If necessary, Principal Life Insurance Company will assist in obtaining a certificate. Once the amount of prior creditable coverage has been determined, you will receive a notice stating the length of any preexisting condition exclusion period that applies to you or your dependents.

### **Special Enrollment Rights**

If you and your dependents decline coverage because you have other health coverage, you may enroll within 31 days following:

- **Loss of eligibility**

Loss of eligibility includes:

- death, divorce, legal separation, or cessation of dependent status
- reduction in work hours or termination of employment
- if the other health coverage is offered through an HMO, or other similar arrangement, and does not provide benefits to individuals who no longer reside, live, or work in the service area (and if the other health coverage is provided in the group market, no other benefit package is available to the individual)
- if the other health coverage no longer offers any benefits to a class of similarly situated individuals

- **Employer contributions have terminated**

- **COBRA or state continuation has exhausted**

Exhaustion of COBRA or state continuation includes:

- failure of the employer or other responsible entity to remit premiums timely
- if continued coverage is offered through an HMO, or other similar arrangement, and does not provide benefits to individuals who no longer reside, live, or work in the service area and no other benefit package is available to the individual
- completion of the maximum continuation period

## **Special Enrollment Rights (continued)**

If you or your dependents have declined coverage, you may enroll within 31 days if there is a change in your family status. This includes:

- marriage
- birth of child
- adoption or placement for adoption

If you or your dependents do not enroll within 31 days, you will be considered a late enrollee and are subject to the Preexisting Condition Exclusion rules.

If you or your dependent child have declined coverage, you and your dependent child may enroll if coverage is requested after the date of a Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN).

If you are already enrolled for coverage, and your dependents have declined coverages, your dependent child may enroll if coverage is requested within 31 days of a court or administrative order to provide health coverage.

## **Special Enrollment Rights Regarding Children's Health Insurance Program (CHIP)**

If you or your dependent are eligible, but not enrolled for coverage, you may enroll for coverage if:

- you or your dependent are covered under a Medicaid or CHIP plan and coverage is terminated as a result of the loss of eligibility of Medicaid or CHIP coverage; or
- you or your dependent become eligible for premium assistance to purchase coverage under the group health plan.

You must enroll no later than 60 days after the date eligibility is lost or the date you or your dependent are determined to be eligible for premium assistance.

If you or your dependent do not enroll within 60 days, you will be considered a late enrollee.

## **Additional Information**

To obtain additional information or assistance, contact:

Principal Life Insurance Company  
Des Moines, IA 50392-0002

Attn: Group Call Center  
Telephone: 1-800-843-1371

## **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 the Health Information section. 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.

Please keep these notices for your records.

# Customized Enrollment Form With Statement of Health

## Template Filing Document

ARKANSAS GP56390-01

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Principal Life Insurance Company uses a word template to create customized enrollment forms which are tailored specifically for each group based on the coverages the group has elected. The template is loaded with each possible piece of an enrollment form and user criteria is identified. The template then uses menus to gather information needed to pull in applicable sections of the form.

The Customized Enrollment Form with Statement of Health also has the capability to merge an excel file containing employee information which then creates an individualized (personalized) enrollment form for each employee. If employee data is merged a cover sheet containing the employee's name and address will appear as the first page of the enrollment. This step is optional.

For the purposes of this template document, each step and section has been provided in the order that it will occur or appear on the form. An explanation of when each will be used is stated above the step or section. Shading is used to help you see where the information pulls from.

The template begins with a Main Screen where the user building the form must complete coverage information, benefits, and provisions elected by the employer. A Dual Option Screen appears to the user if they elect a dental dual option plan on the Main Screen. The Dual Option Screen allows the user to enter a description of each dental plan design and whether the employer is contributing towards the premium amount. This is used when an employer offers more than one dental plan to their employees.

Enrollment sections, along with a description of when they will be used, will follow. Fields in   are populated with information entered on the Main Screen or Dual Option Screen. Fields in   are populated using information from the optional Excel file or this information can be entered manually as an employee completes the form.

This section always pulls in  
  Pulls from the Main Screen  
  Pulls from the Excel census file

110



Mailing Address  
Des Moines, IA 50392-0002

Principal Life  
Insurance Company

Employee  
Enrollment &  
Waiver - AR

Company name <span style="background-color: yellow;"> </span>	Division level <span style="background-color: yellow;"> </span>	Account number/unit number <span style="background-color: yellow;"> </span>
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**Employee Information**

Name <span style="background-color: #800000;"> </span> <span style="background-color: #800000;"> </span>			Social security number <span style="background-color: #800000;"> </span>	
Mailing address (street) <span style="background-color: #800000;"> </span>			Birth date <span style="background-color: #800000;"> </span>	<input checked="" type="checkbox"/> male <input type="checkbox"/> female
(city) <span style="background-color: #800000;"> </span>	(state) <span style="background-color: #800000;"> </span>	(ZIP code) <span style="background-color: #800000;"> </span>	Do you have an eligible spouse or child? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Date employed full-time <span style="background-color: #800000;"> </span>	Hours worked per week <span style="background-color: #800000;"> </span>	Job occupation/class <span style="background-color: #800000;"> </span>	Employer ZIP/Location <span style="background-color: yellow;"> </span> / <span style="background-color: #800000;"> </span>	

\*\*\*\*\*

This section pulls in if a non-medical coverage (Life, VTL, STD, LTD) is selected on the Main Screen.

  Pulls from the Main Screen  
  Pulls from the Excel census file

Salary amount <span style="background-color: #800000;"> </span>	Salary mode <input checked="" type="checkbox"/> yearly <input checked="" type="checkbox"/> weekly <input checked="" type="checkbox"/> hourly <input checked="" type="checkbox"/> monthly <input checked="" type="checkbox"/> bi-weekly			
What is your payroll mode? <input type="checkbox"/> monthly <input type="checkbox"/> semi-monthly <input type="checkbox"/> weekly <input type="checkbox"/> bi-weekly			Employer county <span style="background-color: yellow;"> </span>	

\*\*\*\*\*

This section pulls in if 1 plan Medical coverage is selected on the Main Screen.

The Decline box pulls in if coverage is contributory which is selected on the Main Screen.

**Medical**

Employee: <input type="checkbox"/> Elect <input checked="" type="checkbox"/> Decline	Spouse: <input type="checkbox"/> Elect <input type="checkbox"/> Decline	Children: <input type="checkbox"/> Elect <input type="checkbox"/> Decline
---	--	--

\*\*\*\*\*

This section pulls in if 2 plan Medical coverage is selected on the Main Screen. This occurs if the employer offers more than one Medical plan choice to their employees.  
The Decline boxes pull in if coverage is contributory, which is selected on the Main Screen.

**Medical**

**Plan 1**

Employee:  Elect  Decline      Spouse:  Elect  Decline      Children:  Elect  Decline

**Plan 2**

Employee:  Elect  Decline      Spouse:  Elect  Decline      Children:  Elect  Decline

\*\*\*\*\*

This section pulls in if 3 plan Medical coverage is selected on the Main Screen. This occurs if the employer offers more than one Medical plan choice to their employees.  
The Decline boxes pull in if coverage is contributory which is selected on the Main Screen.

**Medical**

**Plan 1**

Employee:  Elect  Decline      Spouse:  Elect  Decline      Children:  Elect  Decline

**Plan 2**

Employee:  Elect  Decline      Spouse:  Elect  Decline      Children:  Elect  Decline

**Plan 3**

Employee:  Elect  Decline      Spouse:  Elect  Decline      Children:  Elect  Decline

\*\*\*\*\*

This section pulls in if Dental coverage is selected on the Main Screen.  
The Decline box pulls in if coverage is contributory which is elected on the Main Screen.  
The Orthodontia statement pulls in if Ortho Coverage is selected on the Main Screen.

**Dental**

Employee:  Elect  Decline      Spouse:  Elect  Decline      Children:  Elect  Decline

In the past 12 months, have you, the applicant, had continuous group orthodontia coverage (for yourself and/or your dependents) with a prior carrier?  Yes  No

\*\*\*\*\*

This section pulls in if Dental coverage is selected on the Main Screen.  
 The Decline boxes pull in if coverage is contributory which is elected on the Main Screen.  
 The Employer Contribution amounts pull in, if applicable, from the Dual Option Screen.  
 The Design Description pulls in from the Dual Option Screen.  
 The Orthodontia statement pulls in if Ortho Coverage is selected on the Main Screen.

**Dental**

Elect  Decline Choose from one of the following plans.

**Plan #1** **Employer Contribution**

Design description:

Employee:	Spouse:	Child:
<input type="checkbox"/> Elect <input checked="" type="checkbox"/> Decline	<input type="checkbox"/> Elect <input type="checkbox"/> Decline	<input type="checkbox"/> Elect <input type="checkbox"/> Decline

**Plan #2** **Employer Contribution**

Design description:

Employee:	Spouse:	Child:
<input type="checkbox"/> Elect <input checked="" type="checkbox"/> Decline	<input type="checkbox"/> Elect <input type="checkbox"/> Decline	<input type="checkbox"/> Elect <input type="checkbox"/> Decline

In the past 12 months, have you, the applicant, had continuous group orthodontia coverage (for yourself and/or your dependents) with a prior carrier?  Yes  No

\*\*\*\*\*

This section pulls in if Vision coverage is selected on the Main Screen.  
 The Decline box pulls in if coverage is contributory which is selected on the Main Screen.

**Vision**

Employee:  Elect  Decline  
 Spouse:  Elect  Decline  
 Children:  Elect  Decline

\*\*\*\*\*

This section pulls in if STD coverage is selected on the Main Screen.  
 The Decline box pulls in if coverage is contributory which is selected on the Main Screen.  
 The Buy-up option pulls in if selected on the Main Screen.

**Short Term Disability**

Employee:  Elect  Decline  
 STD Buy-up option, check one:  Elect  Decline

\*\*\*\*\*

This section pulls in if LTD coverage is selected on the Main Screen.  
 The Decline box pulls in if coverage is contributory which is selected on the Main Screen.  
 The Buy-up option pulls in if selected on the Main Screen.

**Long Term Disability**

Employee:  Elect  Decline  
 LTD Buy-up option, check one:  Elect  Decline

\*\*\*\*\*

This section pulls in if Group Term Life coverage is selected on the Main Screen.  
 The Decline box pulls in if coverage is contributory which is selected on the Main Screen.

<b>Group Term Life</b>	
Employee:	
<input type="checkbox"/> Elect	<input checked="" type="checkbox"/> Decline

\*\*\*\*\*

This section pulls in if Group Term Life with Dependent Life coverage is selected on the Main Screen.  
 The Decline boxes pull in if coverage is contributory which is selected on the Main Screen.

<b>Group Term Life</b>			
Employee:		Dependent Life:	
<input type="checkbox"/> Elect	<input checked="" type="checkbox"/> Decline	<input type="checkbox"/> Elect	<input checked="" type="checkbox"/> Decline

\*\*\*\*\*

This section pulls in if Supplemental Term Life Increment coverage is selected on the Main Screen.

<b>Supplemental Term Life</b>	
Employee: <input type="checkbox"/> Elect <input type="checkbox"/> Decline    \$ _____	

\*\*\*\*\*

This section pulls in if Supplemental Term Life Salary coverage is selected on the Main Screen.

<b>Supplemental Term Life</b>	
Employee: <input type="checkbox"/> Elect <input type="checkbox"/> Decline    _____ x annual salary	

\*\*\*\*\*

This section pulls in if Voluntary Term Life Increments Smoker/Non Smoker coverage is selected on the Main Screen.

<b>Voluntary Term Life</b>		
Employee: <input type="checkbox"/> Elect <input type="checkbox"/> Decline	\$ _____	
Have you used nicotine products (including cigarette, pipe, cigar or chewing tobacco) in past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Spouse: <input type="checkbox"/> Elect <input type="checkbox"/> Decline	\$ _____	Birth date
Has your spouse used nicotine products (including cigarette, pipe, cigar or chewing tobacco) in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Children: <input type="checkbox"/> Elect <input type="checkbox"/> Decline	\$ _____	

\*\*\*\*\*

This section pulls in if Voluntary Term Life Increments Smoker/Non Smoker Employee Only coverage is selected on the Main Screen.

<b>Voluntary Term Life</b>	
Employee: <input type="checkbox"/> Elect <input type="checkbox"/> Decline	\$ _____
Have you used nicotine products (including cigarette, pipe, cigar or chewing tobacco) in past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No	

\*\*\*\*\*

This section pulls in if Voluntary Term Life Increments Unismoker coverage is selected on the Main Screen.

Voluntary Term Life		
Employee:	<input type="checkbox"/> Elect <input type="checkbox"/> Decline	\$ _____
Spouse:	<input type="checkbox"/> Elect <input type="checkbox"/> Decline	\$ _____
		Birth date
Children:	<input type="checkbox"/> Elect <input type="checkbox"/> Decline	\$ _____

\*\*\*\*\*

This section pulls in if Voluntary Term Life Increments Unismoker Employee Only coverage is selected on the Main Screen.

Voluntary Term Life	
Employee:	<input type="checkbox"/> Elect <input type="checkbox"/> Decline   \$ _____

\*\*\*\*\*

This section pulls in if Voluntary Term Life Percent of Salary Smoker/Non Smoker coverage is selected on the Main Screen.

Voluntary Term Life	
Employee:	<input type="checkbox"/> Elect <input type="checkbox"/> Decline   _____ x annual salary
Have you used nicotine products (including cigarette, pipe, cigar or chewing tobacco) in past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Spouse:	<input type="checkbox"/> Elect <input type="checkbox"/> Decline   \$ _____
	Birth date
Has your spouse used nicotine products (including cigarette, pipe, cigar or chewing tobacco) in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Children:	<input type="checkbox"/> Elect <input type="checkbox"/> Decline   \$ _____

\*\*\*\*\*

This section pulls in if Voluntary Term Life Percent of Salary Smoker/Non Smoker Employee Only coverage is selected on the Main Screen.

Voluntary Term Life	
Employee:	<input type="checkbox"/> Elect <input type="checkbox"/> Decline   _____ x annual salary
Have you used nicotine products (including cigarette, pipe, cigar or chewing tobacco) in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No	

\*\*\*\*\*



Name	Percentage	Relationship
Address		Social security number

\*\*\*\*\*

This section pulls in if Voluntary Term Life is selected on the Main Screen.  
 The "same as" and "NOTE:" statements pull in if Group Term Life and Voluntary Term Life coverage is selected on the Main Screen.

**Voluntary Term Life Beneficiary Designation** (Complete if covered for voluntary term life coverage. If you want to use the same beneficiary designation as indicated for group term life coverage above, write "same as above" in the beneficiary section below.)

All primary and contingent beneficiaries, whether adults or minors, should be included in the beneficiary designation below.

**Primary Beneficiaries:**

Name	Percentage	Relationship
Address		Social security number
Name	Percentage	Relationship
Address		Social security number
Name	Percentage	Relationship
Address		Social security number

**Contingent Beneficiaries:**

Name	Percentage	Relationship
Address		Social security number
Name	Percentage	Relationship
Address		Social security number

The right to make future changes is reserved. If two or more beneficiaries are named, the proceeds shall be paid to the named beneficiaries, or to the survivor or survivors, in equal shares, unless specified otherwise.

If any beneficiary is designated as trustee, it is understood and agreed that Principal Life Insurance Company shall not be a party to nor bound by the conditions of any trust and payment of the net proceeds of said policy on the death of the insured to the then designated beneficiary shall be a complete discharge as to Principal Life.

If you have designated a minor child(ren) as your beneficiary, you must complete the Uniform Transfers to Minors Act form.

**NOTE:** You are covered by both group term life and voluntary term life coverage and if you only indicate a beneficiary designation for one of these, the facility of payment provision in the group policy will be used to determine how proceeds will be paid for the other coverage.

\*\*\*\*\*

This section pulls in if Dental, Voluntary Term Life, Medical, Vision, or Group Term Dependent Life coverage is selected on the Main Screen.

The first foster child question pulls in if they have not renewed to Health Care Reform

The second foster child question pulls in if Health Care Reform.

**Eligible Dependent Information** (Complete if you have elected benefits for your spouse or children)

Spouse's name	Birth date	<input type="checkbox"/> male <input type="checkbox"/> female	Social security number	
Name(s) of child(ren)	Birth date	<input type="checkbox"/> male <input type="checkbox"/> female	Social security number	<input type="checkbox"/> foster child* <input type="checkbox"/> disabled or handicapped child **
		<input type="checkbox"/> male <input type="checkbox"/> female		<input type="checkbox"/> foster child* <input type="checkbox"/> disabled or handicapped child **
		<input type="checkbox"/> male <input type="checkbox"/> female		<input type="checkbox"/> foster child* <input type="checkbox"/> disabled or handicapped child **

\* If you checked foster child, do you provide principal support and does the child(ren) live with you at least 50% of the time?  Yes  No

\* If you checked foster child, was the child placed with you by an authorized state placement agency or by order of a court?  Yes  No

\*\* When your child, who is developmentally disabled or physically handicapped, reaches/exceeds the maximum age, an Application to Continue Handicapped Child form must be completed and reviewed to determine eligibility.

Is your spouse employed by this company?  Yes  No

\*\*\*\*\*

This section pulls in if 51 lives or more is selected on the Main Screen.

The "Read the Notice of Information Practices prior to answering" statement pulls in if Short Term Disability, Long Term Disability, Group Term Life, or Voluntary Term Life is selected on the Main Screen. NOTE: The medical conditions are each shown as a variable and could be removed if it is determined in the future that utilization patterns and treatment methods no longer require us to ask about a specific condition. These conditions would not be removed on a group-by-group basis and this type of change would only be implemented for all groups using the form from a specific date forward.

**Health Information Questions – Groups with 51+ lives** (Read the Notice of Information Practices prior to answering)

To prevent delays give full details to "yes" answers for everyone electing coverage. If more space is needed, attach a separate page giving full details. Sign and date all pages. 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 In the past five years, has anyone 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 OR been diagnosed or received treatment for any of the following conditions or disorders? (Check ALL that apply.) If a condition is not noted, please list it.

- [cancer]       [alcohol] [/drug use]       [arthritis] [/bone] [/joint] [/muscle]       [skin] [/eye] [/ear] [/nose] [/throat]
- [tumor]       [liver] [/hepatitis]       [allergy] [/asthma] [/respiratory]       [kidney] [/bladder] [/urinary]
- [infertility]       [heart] [/circulatory]       [digestive] [/intestinal] [/eating]       [stroke] [/neurological] [/nervous system]
- [high cholesterol]       [mental] [/nervous]       high blood pressure [- last reading and date \_\_\_\_\_ / \_\_\_\_\_]
- [diabetes – last HbA1c reading and date \_\_\_\_\_ / \_\_\_\_\_]       [organ or other transplants]

- [acquired immune deficiency syndrome (AIDS)/infection with HIV (human immunodeficiency virus)/other immune disorder]
- [any current pregnancies (due date: \_\_\_\_\_)]  [other – including other meds]
- [any pending or scheduled surgery, any surgery or incurred medical/pharmacy claims in excess of \$5,000 (before insurance payment)?]
- [tobacco use (which applicant: \_\_\_\_\_)]

Name	Date diagnosed/treated	Length of illness or condition
Diagnosis of illness or condition	Type of treatment	
Names of all medications		
Any current symptoms or problems		Doctor and hospital names and addresses

Name	Date diagnosed/treated	Length of illness or condition
Diagnosis of illness or condition	Type of treatment	
Names of all medications		
Any current symptoms or problems		Doctor and hospital names and addresses

Name	Date diagnosed/treated	Length of illness or condition
Diagnosis of illness or condition	Type of treatment	
Names of all medications		
Any current symptoms or problems		Doctor and hospital names and addresses

\*\*\*\*\*

This section pulls in if less than 51 lives is selected on the Main Screen.  
 The "Read the Notice of Information Practices prior to answering" statement pulls in if Short Term Disability, Long Term Disability, Group Term Life, or Voluntary Term Life is selected on the Main Screen.  
 NOTE: The medical conditions are each shown as a variable and could be removed if it is determined in the future that utilization patterns and treatment methods no longer require us to ask about a specific condition. These conditions would not be removed on a group-by-group basis and this type of change would only be implemented for all groups using the form from a specific date forward.

**Health Information Questions (Read the Notice of Information Practices prior to answering)**

To prevent delays give full details to "yes" answers for everyone electing coverage. If more space is needed, attach a separate page giving full details. Sign and date all pages. 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 anyone planning or scheduled for hospitalization, surgery, medical treatment, therapy, counseling, medical tests or examinations or taking any medicine or is anyone pregnant (due date \_\_\_\_\_ any complications \_\_\_\_\_ C-Section date \_\_\_\_\_ Multiple births?  Yes  No )

2.  Yes  No In the past five years, has anyone 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 OR been diagnosed or received treatment for any of the following conditions or disorders? (Check ALL that apply.) If a condition is not noted, please list it.

- [cancer]     
  [alcohol] [/drug use]     
  [arthritis] [/bone] [/joint] [/muscle]     
  [skin] [/eye] [/ear] [/nose] [/throat]
- [tumor]     
  [liver] [/hepatitis]     
  [allergy] [/asthma] [/respiratory]     
  [kidney] [/bladder] [/urinary]
- [infertility]     
  [heart] [/circulatory]     
  [digestive] [/intestinal] [/eating]     
  [stroke] [/neurological] [/nervous system]
- [high cholesterol]     
  [mental] [/nervous]     
 high blood pressure [- last reading and date \_\_\_\_ / \_\_\_\_ ]
- [diabetes – last HbA1c reading and date \_\_\_\_ / \_\_\_\_ ]     
 [organ or other transplants]
- [acquired Immune Deficiency Syndrome (AIDS)/infection with HIV (Human Immunodeficiency Virus)/other immune disorder]
- [other – including other meds]     
 [tobacco use (which applicant: \_\_\_\_\_ ) ]

Name	Date diagnosed/treated	Length of illness or condition
Diagnosis of illness or condition	Type of treatment	
Names of all medications		
Any current symptoms or problems	Doctor and hospital names and addresses	

Name	Date diagnosed/treated	Length of illness or condition
Diagnosis of illness or condition	Type of treatment	
Names of all medications		
Any current symptoms or problems	Doctor and hospital names and addresses	

Name	Date diagnosed/treated	Length of illness or condition
Diagnosis of illness or condition	Type of treatment	
Names of all medications		
Any current symptoms or problems	Doctor and hospital names and addresses	

\*\*\*\*\*

This section pulls in if ONLY Medical coverage is selected on the Main Screen. If a non-medical coverage (Life, VTL, STD, LTD, Dental, Vision) is elected then this section will pull in later in the form.

**I declare** that the information I have completed on this enrollment form is complete and true. I understand an agent or broker cannot guarantee coverage, revise rates, benefits or provisions without written approval from Principal Life.

**Your signature X** \_\_\_\_\_ **Date Signed** \_\_\_\_\_

\*\*\*\*\*

This section always pulls in.  
 The first yellow bullet only pulls in if Dental coverage is selected on the Main Screen.  
 The second yellow bullet only pulls in if Medical coverage is selected on the Main Screen.  
 The third yellow bullet only pulls in if Short Term Disability, Long Term Disability, Group Term Life, or Voluntary Term Life.  
 The fourth yellow bullet pulls in if Health Care Reform does not apply

The fifth yellow bullet pulls in if Health Care Reform applies

The sixth yellow bullet only pulls in if Short Term Disability, Long Term Disability, Group Term Life, or Voluntary Term Life.

The seventh yellow bullet only pulls in if Group Term Life or Voluntary Term Life.

The eighth yellow bullets only pull in if Medical is selected on the Main Screen.

**Principal<sup>®</sup>**

**Financial  
Group**

Mailing Address  
Des Moines, IA 50392-0002

**Principal Life  
Insurance Company**

**Employee  
Enrollment &  
Waiver - AR**

### Employee Agreement (Read and sign)

I understand and agree with the following statements:

- My dependents are not eligible for coverages I don't have. My dependents, including step and foster children and any over the maximum age, are eligible based on plan provisions but those over the maximum age will be verified when a claim is filed.
- If I refuse dental coverage, I and my dependents may enroll later but this will affect the level of benefits.
- I have read and understand the Preexisting Condition Exclusion and the Special Enrollment Rights and know if I refuse medical coverage, I and my dependents must wait for the next open enrollment unless I become eligible during a Special Enrollment.
- If I refuse coverage, I cannot enroll after retirement.
- If I refuse life or disability coverage, I may apply later but I must show proof of good health and coverage will be subject to approval by Principal Life Insurance Company.
- If the group policy does not require my contribution, I cannot decline coverage unless the policy indicates otherwise.
- If the group policy requires my contribution, I authorize my employer to deduct from my pay.
- I represent all information on this form and attachments is complete and true to the best of my knowledge. They are part of this request for coverage. I agree Principal Life is not liable for a claim before the effective date of coverage and all policy provisions apply. I have read, or had read to me, the information and my answers on this form. During the first two years coverage is in force, false statements, omissions, or material misrepresentations can cause changes in my coverage, including cancellation back to the effective date.
- I represent all information on this form and attachments is complete and true to the best of my knowledge. They are part of this request for coverage. I agree Principal Life is not liable for a claim before the effective date of coverage and all policy provisions apply. I have read, or had read to me, the information and my answers on this form. During the first two years coverage is in force, fraud or intentional misrepresentations can cause changes in my coverage, including cancellation back to the effective date.
- Any person who, with intent to defraud or knowingly is facilitating a fraud against an insurer, submits an application or files a claim with false or deceptive statements, may be guilty of insurance fraud.
- For life and disability coverages, I authorize any health care provider who has personal information, including physical, mental, drug or alcohol use history, regarding me or a dependent, to give such data to Principal Life agents and employees performing my business transactions.
- I authorize Principal Life to release data as required by law. If signed in connection with an application, reinstatement or a change in benefits, this form will be valid two years from the date below. I may revoke authorization for information not yet obtained. I understand data obtained will be used by Principal Life for claims administration and determining eligibility for life and disability coverage. Information will not be used for any purposes prohibited by law.
- Explanation of Benefits reflecting claims payments for myself or my dependents will be sent to my home address. I also understand collection of social security numbers for myself or my dependents will be used by Principal Life only as allowed by law.
- For life coverage, I understand that as the employee, the insurance I and my dependents have applied for will begin on the effective date of coverage provided I am at work on that date. If I am not actively at work on such date, subject to the terms of the group policy, coverage may not go into effect until after my return to work. Furthermore, I understand that no insurance may become effective for any member of my family while he/she is in a period of limited activity.
- For medical coverage, I authorize pharmacy benefit managers, "health care providers", and entities covered under the HIPAA Privacy Rule and their agents and employees, to disclose my personal health information to Principal Life, its agents, and employees, for purposes of underwriting my application for coverage, and making eligibility, premium rating, and enrollment decisions, relating to any coverage I have, have applied for, or may in the future apply for with Principal Life or other entities covered under the HIPAA Privacy Rule. This includes information concerning the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection, sexually transmitted diseases, mental illness, and the use of alcohol, drugs, and tobacco. This authorization shall remain in force for two years following the date of my signature. I may revoke this authorization in writing at any time by sending the request for revocation to: Health Information Protection Analyst, Group Compliance, Principal Life Insurance Company, Des Moines, IA 50392-0002. A revocation is not effective if Principal Life has relied on the protected health information disclosed to it. Any information disclosed under this authorization may no longer be covered by privacy provisions of HIPAA and may be subject to redisclosure. I understand that if I refuse this authorization, Principal Life may not make an eligibility determination, and I will not be considered for coverage with Principal Life. I have read and I understand this authorization.

A copy of this form will be as valid as the original.

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This section pulls in here if a non-medical coverage (Life, VTL, STD, LTD, Dental, Vision) is selected on the Main Screen. I declare that the information I have completed on this enrollment form is complete and true. I understand an agent or broker cannot guarantee coverage, revise rates, benefits or provisions without written approval from Principal Life.

Your signature X \_\_\_\_\_ Date Signed \_\_\_\_\_

\*\*\*\*\*

This section pulls in if a Medical coverage is selected and Health Care Reform does not apply on the Main Screen.



Mailing Address  
Des Moines, IA 50392-0002

Principal Life  
Insurance Company

Employee  
Enrollment &  
Waiver - AR

Federal Regulations require an employee to receive the following notices for medical coverage offered.

**Preexisting Condition Exclusion**

Preexisting Conditions Exclusions apply to individuals covered on the policy issue date of a new group whose prior coverage was 12 months or less; and late enrollees.

A preexisting condition is a condition present before your enrollment date in any new health plan. If you or your dependents received, or were recommended to receive medical advice, diagnosis, care, or treatment for a condition (physical or mental), in the last six months, the preexisting exclusion will apply. This preexisting exclusion period is 12 months and will exclude benefits for any treatment or service during the preexisting condition period.

Late enrollees may not enroll until the next annual open enrollment period at which time the preexisting condition exclusion period will apply. The preexisting exclusion will not apply to newborns or children under the age of 18 whom are adopted or placed for adoption if coverage is requested within 31 days of birth, adoption or placement for adoption; or pregnancy.

The preexisting exclusion period may be reduced by the number of days you or your dependents were covered under a prior health plan. You and your dependents have the right to demonstrate previous coverage by requesting a certificate of coverage from your prior health plan. If necessary, Principal Life Insurance Company will assist in obtaining a certificate. Once the amount of prior creditable coverage has been determined, you will receive a notice stating the length of any preexisting condition exclusion period that applies to you or your dependents.

**Special Enrollment Rights**

If you and your dependents decline coverage because you have other health coverage, you may enroll within 31 days following:

**Loss of eligibility**

Loss of eligibility includes:

- death, divorce, legal separation, or cessation of dependent status
- reduction in work hours or termination of employment
- if the other health coverage is offered through an HMO, or other similar arrangement, and does not provide benefits to individuals who no longer reside, live, or work in the service area (and if the other health coverage is provided in the group market, no other benefit package is available to the individual)
- an incurred claim that would meet or exceed a lifetime limit on all benefits
- if the other health coverage no longer offers any benefits to a class of similarly situated individuals

**Employer contributions have terminated**

**COBRA or state continuation has exhausted**

Exhaustion of COBRA or state continuation includes:

- failure of the employer or other responsible entity to remit premiums timely
- if continued coverage is offered through an HMO, or other similar arrangement, and does not provide benefits to individuals who no longer reside, live, or work in the service area and no other benefit package is available

to the individual

- an incurred claim that would meet or exceed a lifetime limit on all benefits
- completion of the maximum continuation period

If you or your dependents have declined coverage, you may enroll within 31 days if there is a change in your family status. This includes:

- marriage
- birth of child
- adoption or placement for adoption

If you or your dependents do not enroll within 31 days, you will be considered a late enrollee and are subject to the Preexisting Condition Exclusion rules.

If you or your dependent child have declined coverage, you and your dependent child may enroll if coverage is requested after the date of a Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN).

If you are already enrolled for coverage, and your dependents have declined coverages, your dependent child may enroll if coverage is requested within 31 days of a court or administrative order to provide health coverage.

### **Additional Information**

To obtain additional information or assistance, contact:

Principal Life Insurance Company  
Des Moines, IA 50392-0002

Attn: Group Call Center  
Telephone: 1-800-843-1371

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This section pulls in if a Medical coverage and Health Care Reform is selected and on the Main Screen.



Mailing Address  
Des Moines, IA 50392-0002

Principal Life  
Insurance Company

Employee  
Enrollment &  
Waiver - AR

Federal Regulations require an employee to receive the following notices for medical coverage offered.

## Preexisting Condition Exclusion

Preexisting Conditions Exclusions apply to individuals covered on the policy issue date of a new group whose prior coverage was 12 months or less; and late enrollees.

A preexisting condition is a condition present before your enrollment date in any new health plan. If you or your dependents received, or were recommended to receive medical advice, diagnosis, care, or treatment for a condition (physical or mental), in the last six months, the preexisting exclusion will apply. This preexisting exclusion period is 12 months and will exclude benefits for any treatment or service during the preexisting condition period.

Late enrollees may not enroll until the next annual open enrollment period at which time the preexisting condition exclusion period will apply. The preexisting exclusion will not apply to pregnancy or to individuals under the age of 19.

The preexisting exclusion period may be reduced by the number of days you or your dependents were covered under a prior health plan. You and your dependents have the right to demonstrate previous coverage by requesting a certificate of coverage from your prior health plan. If necessary, Principal Life Insurance Company will assist in obtaining a certificate. Once the amount of prior creditable coverage has been determined, you will receive a notice stating the length of any preexisting condition exclusion period that applies to you or your dependents.

## Special Enrollment Rights

If you and your dependents decline coverage because you have other health coverage, you may enroll within 31 days following:

- **Loss of eligibility**

Loss of eligibility includes:

- death, divorce, legal separation, or cessation of dependent status
- reduction in work hours or termination of employment
- if the other health coverage is offered through an HMO, or other similar arrangement, and does not provide benefits to individuals who no longer reside, live, or work in the service area (and if the other health coverage is provided in the group market, no other benefit package is available to the individual)
- if the other health coverage no longer offers any benefits to a class of similarly situated individuals

- **Employer contributions have terminated**

- **COBRA or state continuation has exhausted**

Exhaustion of COBRA or state continuation includes:

- failure of the employer or other responsible entity to remit premiums timely
- if continued coverage is offered through an HMO, or other similar arrangement, and does not provide benefits to individuals who no longer reside, live, or work in the service area and no other benefit package is available to the individual
- completion of the maximum continuation period

If you or your dependents have declined coverage, you may enroll within 31 days if there is a change in your family status. This includes:

- marriage
- birth of child
- adoption or placement for adoption

If you or your dependents do not enroll within 31 days, you will be considered a late enrollee and are subject to the Preexisting Condition Exclusion rules.

If you or your dependent child have declined coverage, you and your dependent child may enroll if coverage is requested after the date of a Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN).

If you are already enrolled for coverage, and your dependents have declined coverages, your dependent child may enroll if coverage is requested within 31 days of a court or administrative order to provide health coverage.

### **Special Enrollment Rights Regarding Children's Health Insurance Program (CHIP)**

If you or your dependent are eligible, but not enrolled for coverage, you may enroll for coverage if:

- you or your dependent are covered under a Medicaid or CHIP plan and coverage is terminated as a result of the loss of eligibility of Medicaid or CHIP coverage; or
- you or your dependent become eligible for premium assistance to purchase coverage under the group health plan.

You must enroll no later than 60 days after the date eligibility is lost or the date you or your dependent are determined to be eligible for premium assistance.

If you or your dependent do not enroll within 60 days, you will be considered a late enrollee.

### **Additional Information**

To obtain additional information or assistance, contact:

Principal Life Insurance Company  
Des Moines, IA 50392-0002

Attn: Group Call Center  
Telephone: 1-800-843-1371

This section pulls in if Short Term Disability, Long Term Disability, Group Term Life, or Voluntary Term Life is selected on the Main Screen.

**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 the Health Information section. 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.

\*\*\*\*\*

This section always pulls in.

Please keep these notices for your records.

**Instructions**

After this form is completed and signed, make two copies and send the original to Principal Life Insurance Company:

- One for the employee
- One for the employer

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SERFF Tracking Number: PRLF-126736744 State: Arkansas  
 Filing Company: Principal Life Insurance Company State Tracking Number: 46556  
 Company Tracking Number:  
 TOI: H16G Group Health - Major Medical Sub-TOI: H16G.001C Any Size Group - Other  
 Product Name: PPACA Filing  
 Project Name/Number: /

## Supporting Document Schedules

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Flesch Certification	Approved-Closed	09/01/2010
<b>Comments:</b>		
<b>Attachment:</b> Readability Cert.pdf		

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Application	Approved-Closed	09/01/2010
<b>Comments:</b> The application is being revised with this filing and is attached under the form schedule as GP45697-08. The previous version of this form GP45697-07 was approved on 9/28/09.		

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> PPACA Uniform Compliance Summary	Approved-Closed	09/01/2010
<b>Comments:</b>		
<b>Attachment:</b> PPACAUniformComplianceSummaryClean.pdf		

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Additional Supporting Documentation	Approved-Closed	09/01/2010
<b>Comments:</b>		
<b>Attachments:</b> 2010 Form Number Listing.pdf Addendum.pdf STATEMENT OF VARIABILITY.pdf Certification.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 5000-2 et al	Group Medical Expense Policy Forms	50.4
GH 100 A-1 et al	Group Medical Expense Booklet-Certificate Forms	50

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

August 19, 2010

\_\_\_\_\_  
Date

12/1999



## PPACA Uniform Compliance Summary

**Please select the appropriate check box below to indicate which product is amended by this filing.**

**INDIVIDUAL HEALTH BENEFIT PLANS** (Complete [SECTION A](#) only)

**SMALL / LARGE GROUP HEALTH BENEFIT PLANS** (Complete [SECTION B](#) only)

This form filing compliance summary is to be submitted with your [endorsement][contract] to comply with the immediate market reform requirements of the Patient Protection and Affordable Care Act (PPACA). These PPACA requirements apply only to policies for health insurance coverage referred to as “major medical” in the statute, which is comprehensive health coverage that includes PPO and HMO coverage. This form includes the requirements for grandfathered (coverage in effect prior to March 23, 2010) and non-grandfathered plans, and relevant statutes. Refer to the relevant statute to ensure compliance. Complete each item to confirm that diligent consideration has been given to each. *(If submitting your filings electronically, bookmark the provision(s) in the form(s) that satisfy the requirement and identify the page/paragraph on this form.)*

Check box if this is a paper filing.

### COMPANY INFORMATION

Company Name	NAIC Number	SERFF Tracking Number(s) *if applicable	Form Number(s) of Policy being endorsed	Rate Impact
				<input type="checkbox"/> Yes <input type="checkbox"/> No

## PPACA Uniform Compliance Summary

### SECTION A – Individual Health Benefit Plans

TOI	Category	Statute Section	Grandfathered	Non-Grandfathered
	<b>Eliminate Pre-existing Condition Exclusions for Enrollees Under Age 19</b>	<i>[Sections 2704 and 1255 of the PHSA/Section 1201 of the PPACA]</i>	N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No If <b>no</b> , please explain.
	Explanation:			
	Page Number:			
	<b>Eliminate Annual Dollar Limits on Essential Benefits</b> Except allows for “restricted” annual dollar limits for essential benefits for plan years prior to January 1, 2014.	<i>[Section 2711 of the PHSA/Section 1001 of the PPACA]</i>	N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No If <b>no</b> , please explain.
	Explanation:			
	Page Number:			
	<b>Eliminate Lifetime Dollar Limits on Essential Benefits</b>	<i>[Section 2711 of the PHSA/Section 1001 of the PPACA]</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No If <b>no</b> , please explain.	<input type="checkbox"/> Yes <input type="checkbox"/> No If <b>no</b> , please explain.
	Explanation:			
	Page Number:			
	<b>Prohibit Rescissions</b> – Except for fraud or intentional misrepresentation of material fact.	<i>[Section 2712 of the PHSA/Section 1001 of PPACA]</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No If <b>no</b> , please explain.	<input type="checkbox"/> Yes <input type="checkbox"/> No If <b>no</b> , please explain.
	Explanation:			
	Page Number:			

## PPACA Uniform Compliance Summary

### SECTION A – Individual Health Benefit Plans

TOI	Category	Statute Section	Grandfathered	Non-Grandfathered
	<p><b>Preventive Services</b> – Requires coverage and prohibits the imposition of cost-sharing for specified preventative services.</p> <p>Explanation:</p> <p>Page Number:</p>	<i>[Section 2713 of the PHSA/Section 1001 of the PPACA]</i>	N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No If <b>no</b> , please explain.
	<p><b>Extends Dependent Coverage for Children Until age 26</b> – If a policy offers dependent coverage, it must include dependent coverage until age 26.</p> <p>Explanation:</p> <p>Page Number:</p>	<i>[Section 2714 of the PHSA/Section 1001 of the PPACA]</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No If <b>no</b> , please explain.	<input type="checkbox"/> Yes <input type="checkbox"/> No If <b>no</b> , please explain.
	<p><b>Appeals Process</b> – Requires establishment of an internal claims appeal process and external review process.</p> <p>Explanation:</p> <p>Page Number:</p>	<i>[Section 2719 of the PHSA/Section 1001 of the PPACA]</i>	N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No If <b>no</b> , please explain.
	<p><b>Emergency Services</b> – Requires plans that cover emergency services to provide such coverage without the need for prior authorization, regardless of the participating status of the provider, and at the in-network cost-sharing level.</p> <p>Explanation:</p> <p>Page Number:</p>	<i>[Section 2719A of the PHSA/Section 10101 of the PPACA]</i>	N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No If <b>no</b> , please explain.

## PPACA Uniform Compliance Summary

### SECTION A – Individual Health Benefit Plans

TOI	Category	Statute Section	Grandfathered	Non-Grandfathered
	<p><b>Access to Pediatricians</b> – Mandates that if designation of a PCP for a child is required, the person be permitted to designate a physician who specialized in pediatrics as the child’s PCP if the provider is in-network.</p> <p>Explanation:</p> <p>Page Number:</p>	<p><i>[Section 2719A of the PHSA/Section 10101 of the PPACA]</i></p>	N/A	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If <b>no</b>, please explain.</p>
	<p><b>Access to OB/GYNs</b> – Prohibits authorization or referral requirements for obstetrical or gynecological care provided by in-network providers who specialize in obstetrics or gynecology.</p> <p>Explanation:</p> <p>Page Number:</p>	<p><i>[Section 2719A of the PHSA/Section 10101 of the PPACA]</i></p>	N/A	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If <b>no</b>, please explain.</p>

## PPACA Uniform Compliance Summary

### SECTION B – Group Health Benefit Plans (Small and Large)

TOI	Category	Statute Section	Grandfathered	Non-Grandfathered
	<b>Eliminate Pre-existing Condition Exclusions for Enrollees Under Age 19</b>	<i>[Sections 2704 of the PHSA/Section 1201 of the PPACA]</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No If <b>no</b> , please explain.	<input type="checkbox"/> Yes <input type="checkbox"/> No If <b>no</b> , please explain.
	Explanation:			
	Page Number:			
	<b>Eliminate Annual Dollar Limits on Essential Benefits –</b> Except allows for “restricted” annual dollar limits for essential benefits for plan years prior to January 1, 2014.	<i>[Section 2711 of the PHSA/Section 1001 of the PPACA]</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No If <b>no</b> , please explain.	<input type="checkbox"/> Yes <input type="checkbox"/> No If <b>no</b> , please explain.
	Explanation:			
	Page Number:			
	<b>Eliminate Lifetime Dollar Limits on Essential Benefits</b>	<i>[Section 2711 of the PHSA/Section 1001 of the PPACA]</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No If <b>no</b> , please explain.	<input type="checkbox"/> Yes <input type="checkbox"/> No If <b>no</b> , please explain.
	Explanation:			
	Page Number:			
	<b>Prohibit Rescissions –</b> Except for fraud or intentional misrepresentation of material fact.	<i>[Section 2712 of the PHSA/Section 1001 of PPACA]</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No If <b>no</b> , please explain.	<input type="checkbox"/> Yes <input type="checkbox"/> No If <b>no</b> , please explain.
	Explanation:			
	Page Number:			

## PPACA Uniform Compliance Summary

### SECTION B – Group Health Benefit Plans (Small and Large)

TOI	Category	Statute Section	Grandfathered	Non-Grandfathered
	<b>Preventive Services</b> – Requires coverage and prohibits the imposition of cost-sharing for specified preventative services	<i>[Section 2713 of the PHSA/Section 1001 of the PPACA]</i>	N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No If <b>no</b> , please explain.
	Explanation:			
	Page Number:			
	<b>Extends Dependent Coverage for Children Until age 26</b> – If a policy offers dependent coverage, it must include dependent coverage until age 26. ◇	<i>[Section 2714 of the PHSA/Section 1001 of the PPACA]</i>	<input type="checkbox"/> Yes <sup>◇</sup> <input type="checkbox"/> No If <b>no</b> , please explain.	<input type="checkbox"/> Yes <input type="checkbox"/> No If <b>no</b> , please explain.
	Explanation:			
	Page Number:			
	<b>Appeals Process</b> – Requires establishment of an internal claims appeal process and external review process.	<i>[Section 2719 of the PHSA/Section 1001 of the PPACA]</i>	N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No If <b>no</b> , please explain.
	Explanation:			
	Page Number:			

◇ For plan years beginning before January 1, 2014, grandfathered group plans are not required to extend coverage to a child until the age of 26 if such child is eligible to enroll in another employee-sponsored plan

## PPACA Uniform Compliance Summary

### SECTION B – Group Health Benefit Plans (Small and Large)

TOI	Category	Statute Section	Grandfathered	Non-Grandfathered
	<p><b>Emergency Services</b> – Requires plans that cover emergency services to provide such coverage without the need for prior authorization, regardless of the participating status of the provider, and at the in-network cost-sharing level.</p> <p>Explanation:</p> <p>Page Number:</p>	<p><i>[Section 2719A of the PHSA/Section 10101 of the PPACA]</i></p>	N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No If <b>no</b> , please explain.
	<p><b>Access to Pediatricians</b> – Mandates that if designation of a PCP for a child is required, the person be permitted to designate a physician who specialized in pediatrics as the child’s PCP if the provider is in-network.</p> <p>Explanation:</p> <p>Page Number:</p>	<p><i>[Section 2719A of the PHSA/Section 10101 of the PPACA]</i></p>	N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No If <b>no</b> , please explain.
	<p><b>Access to OB/GYNs</b> – Prohibits authorization or referral requirements for obstetrical or gynecological care provided by in-network providers who specialize in obstetrics or gynecology.</p> <p>Explanation:</p> <p>Page Number:</p>	<p><i>[Section 2719A of the PHSA/Section 10101 of the PPACA]</i></p>	N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No If <b>no</b> , please explain.

Policy and Booklet-Certificate Forms Listing for  
Policy Amendment GC 801 PPACA and Booklet-Certificate Rider GH 198 PPACA

Company: Principal Life Insurance Company

Company FEIN: 42-0127290

SERFF Filing Number: PRLF-126736744

Policy Form Number	Title
GC 5002-5	PART I – DEFINITIONS
GC 5003-4	PART II – POLICY ADMINISTRATION – Section A – Contracts
GC 5003 SE-4	PART II – POLICY ADMINISTRATION – Section A – Contracts (Small Employers)
GC 5012 (R)	PART IV – BENEFITS – Section A – Medical Expense Insurance (General Provisions)
GC 5014 AR (R)	PART IV – BENEFITS – Section A (1) Comprehensive Medical Expense Insurance [(PPO)]
GC 5014 A (R)	PART IV – BENEFITS – Section A (2) – Comprehensive Medical Expense Insurance [(PPO)] – [Copay] [and] Deductible Amount and Out-of-Pocket and Coinsurance
GC 5014 B (R)	PART IV – BENEFITS – Section A (3) – Comprehensive Medical Expense Insurance [(PPO)] – Covered Charges
GC 5014 C AR-2	PART IV – BENEFITS – Section A (4) – Comprehensive Medical Expense Insurance [(PPO)] – Mental Health, Behavioral, Alcohol or Drug Abuse Treatment Services
GC 5014 D (R)	PART IV – BENEFITS – Section A (5) – Comprehensive Medical Expense Insurance [(PPO)], - Transplant Services
GC 5014 F (R)	PART IV – BENEFITS – Section A (7) – Comprehensive Medical Expense Insurance [(PPO)] – Wellness Services
GC 5014 G (R)	PART IV – BENEFITS – Section A (8) – Comprehensive Medical Expense Insurance [(PPO)] – Rehabilitative Services
GC 5014 K (R)	PART IV – BENEFITS – Section A (12) – Comprehensive Medical Expense Insurance [(PPO)] – Durable Medical Equipment
GC 5014 L-1	PART IV – BENEFITS – Section A (13) – Comprehensive Medical Expense Insurance [(PPO)] – Prosthetics
GC 5014 M AR-1	PART IV – BENEFITS – Section A (14) – Comprehensive Medical Expense Insurance [(PPO)] – Hospice Care
GC 5014 Q AR-2	PART IV – BENEFITS – Section A (18) – Comprehensive Medical Expense Insurance [(PPO)] – Limitations

Policy and Booklet-Certificate Forms Listing for  
Policy Amendment GC 801 PPACA and Booklet-Certificate Rider GH 198 PPACA

Company: Principal Life Insurance Company

Company FEIN: 42-0127290

SERFF Filing Number: PRLF-126736744

GC 5014 (HDHP) (R)	PART IV – BENEFITS – Section A (1) Comprehensive Medical Expense Insurance [(PPO)]
GC 5014 A (HDHP) (R)	PART IV – BENEFITS – Section A (2) – Comprehensive Medical Expense Insurance [(PPO)] –Deductible Amount and Out-of-Pocket
GC 5014 B (HDHP) (R)	PART IV – BENEFITS – Section A (3) – Comprehensive Medical Expense Insurance [(PPO)] – Covered Charges
GC 5014 C (HDHP) AR-2	PART IV – BENEFITS – Section A (4) – Comprehensive Medical Expense Insurance [(PPO)] – Mental Health, Behavioral, Alcohol or Drug Abuse Treatment Services
GC 5014 D (HDHP) (R)	PART IV – BENEFITS – Section A (5) – Comprehensive Medical Expense Insurance [(PPO)], - Transplant Services
GC 5014 F (HDHP) (R)	PART IV – BENEFITS – Section A (7) – Comprehensive Medical Expense Insurance[(PPO)] – Wellness Services
GC 5014 G (HDHP) (R)	PART IV – BENEFITS – Section A (8) – Comprehensive Medical Expense Insurance [(PPO)] – Rehabilitative Services
GC 5014 K (HDHP) (R)	PART IV – BENEFITS – Section A (12) – Comprehensive Medical Expense Insurance [(PPO)] – Durable Medical Equipment
GC 5014 L (HDHP)-1	PART IV – BENEFITS – Section A (13) – Comprehensive Medical Expense Insurance [(PPO)] – Prosthetics
GC 5014 M (HDHP)-1	PART IV – BENEFITS – Section A (14) – Comprehensive Medical Expense Insurance [(PPO)] – Hospice Care
GC 5014 Q (HDHP) AR-2	PART IV – BENEFITS – Section A (18) – Comprehensive Medical Expense Insurance [(PPO)] – Limitations
GC 5013 AR (R)	PART IV – BENEFITS – Section B (1) – Comprehensive Medical Expense Insurance (Indemnity)
GC 5013 A (R)	PART IV – BENEFITS – Section B (2) – Comprehensive Medical Expense Insurance – Deductible [and Copay] Amounts
GC 5013 B (R)	PART IV – BENEFITS – Section B (3) – Comprehensive Medical Expense Insurance – Covered Charges

Policy and Booklet-Certificate Forms Listing for  
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GC 5013 C AR-2	PART IV – BENEFITS – Section A (4) – Comprehensive Medical Expense Insurance – Mental Health, Behavioral, Alcohol or Drug Abuse Treatment Services
GC 5013 D (R)	PART IV – BENEFITS – Section B (5) – Comprehensive Medical Expense Insurance – Transplant Services
GC 5013 F (R)	PART IV – BENEFITS – Section B (7) – Comprehensive Medical Expense Insurance – Wellness Services
GC 5013 G (R)	PART IV – BENEFITS – Section B (8) – Comprehensive Medical Expense Insurance – Rehabilitative Services
GC 5013 K	PART IV – BENEFITS – Section B (12) – Comprehensive Medical Expense Insurance – Durable Medical Equipment
GC 5013 L-1	PART IV – BENEFITS – Section B (13) – Comprehensive Medical Expense Insurance – Prosthetics
GC 5013 M	PART IV – BENEFITS – Section B (14) – Comprehensive Medical Expense Insurance – Hospice Care
GC 5013 Q AR-2	PART IV – BENEFITS – Section B (18) – Comprehensive Medical Expense Insurance – Limitations
GC 5027 A	PART IV – BENEFITS – Section E- Preexisting Condition Exclusion
GC 5027 B	PART IV – BENEFITS – Section E- Preexisting Condition Exclusion

**BOOKLET FORMS LISTING**

New Booklet Form Number	Title
GH 104 A-5	Summary of Benefits (Indemnity)
GH 104 B-6	Summary of Benefits (PPO)
GH 104 B (HDHP)-3	Summary of Benefits (PPO) (HDHP)
GH 115 A (MED) (R)	How to be Insured – Members

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GH 410 (R)	Description of Benefits – Payment Provisions
GH 411 A (R)	Description of Benefits – Covered Charges – PPO
GH 411 B AR-2	Description of Benefits – Mental Health, Behavioral, Alcohol or Drug Abuse
GH 411 C (R)	Description of Benefits – Transplant Services
GH 411 E (R)	Description of Benefits – Wellness Services
GH 411 F (R)	Description of Benefits – Rehabilitative Services
GH 411 J	Description of Benefits – Durable Medical Equipment
GH 411 K-1	Description of Benefits – Prosthetics
GH 411 L	Description of Benefits – Hospice
GH 411 O AR-2	Description of Benefits – Limitations
GH 411 A (HDHP) (R)	Description of Benefits – Covered Charges
GH 411 B (HDHP) AR-2	Description of Benefits – Mental Health, Behavioral, Alcohol or Drug Abuse
GH 411 C (HDHP) (R)	Description of Benefits – Transplant Services
GH 411 E (HDHP) (R)	Description of Benefits – Wellness Services
GH 411 F (HDHP) (R)	Description of Benefits – Rehabilitative Services
GH 411 J (HDHP)	Description of Benefits – Durable Medical Equipment
GH 411 K (HDHP)-1	Description of Benefits – Prosthetics
GH 411 L (HDHP)	Description of Benefits – Hospice
GH 411 O (HDHP) AR-2	Description of Benefits – Limitations
GH 412 A (R)	Description of Benefits – Covered Charges
GH 412 B AR-2	Description of Benefits – Mental Health, Behavioral, Alcohol or Drug Abuse
GH 412 C (R)	Description of Benefits – Transplant Services
GH 412 E (R)	Description of Benefits – Wellness Services
GH 412 F (R)	Description of Benefits – Rehabilitative Services
GH 412 J	Description of Benefits – Durable Medical Equipment

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GH 412 K-1	Description of Benefits – Prosthetics
GH 412 L	Description of Benefits – Hospice
GH 412 O AR-2	Description of Benefits – Limitations
GH 136 A (MED)-5	Definitions
GH 451 A	Description of Benefits – Preexisting Condition Exclusion
GH 451 B	Description of Benefits – Preexisting Condition Exclusion

Below is a list of all associated documents filed with this Amendment and Rider.

**APPLICATION FORM NUMBERS**

<b>New Application Number</b>	<b>Title</b>
GP45697-08	Employer Application for Group Insurance
GP59181	Employee Enrollment and Waiver Form (with Health Questions)
GP56390-01	Employee Enrollment and Waiver Form template (with health questions)

**ADDENDUM – ARKANSAS PPACA APPLICATION FORMS LIST REVISION**  
**DESCRIPTION**

A list of Group products that will be using these forms is included at the end of this Addendum. Only changes to bring these forms into compliance with the requirements of PPACA have been made to these forms. Any exceptions to the product list are described in the specific form information included below.

1. Employer Application for Group Insurance (GP45697-08) – This form is being revised to change the fraud statement to refer to intentional misrepresentation (see page 6) in compliance with the PPACA regulations. This form replaces the previously filed and approved Employer Application Forms as noted on the Forms Schedule tab for new business sold after the date of approval of this form.
  
2. Employee Enrollment and Waiver Form (with health questions) (GP59181) – This form combines an employee enrollment form and a health statement. This form is new but is the same as our previously filed and approved Employee Enrollment and Waiver form (with health questions) GP48656-06 and will be used to enroll employees for new groups as well as existing groups after the date of approval of this form, if the group is subject to PPACA. GP48656-06 was approved on October 27, 2008, and will continue to be used until a group is renewed into PPACA compliance. Here is a brief list of the items that were changed on this form:
  - Eligible Dependent section – the foster child question has been revised.
  - Employee Agreement section - the bullet regarding misrepresentations has been revised to refer to fraud or intentional misrepresentation.
  - Preexisting Condition Exclusion and Special Enrollment Rights section – the preexisting provision has been revised and a section on Special Enrollment Rights for Children’s Health Insurance Program (CHIP) has been added.
  
3. Employee Enrollment and Waiver form template (with health questions) (GP56390-01) – This form is similar to the enrollment form described in item 2 above, however, the content of this form varies based on the coverages elected by the policyholder, so the form is customized to match the specific coverages for each policyholder that elects to use the form. This enrollment form is produced by personal computer. If a specific policyholder elects just life and medical coverage, only these two coverages will appear on the form. The attached template indicates what text will be pulled into the actual form depending on the coverages elected by the policyholder. See the information shown in red font on the template – this text will not appear on the final enrollment form created for a specific policyholder. This form replaces the previously filed and approved enrollment form template as noted on the Forms Schedule tab for new business as well as existing groups after the date of approval of this form.

The form now includes additional variables that will be used if a group is subject to PPACA (these changes are explained on the template in the red font described above). The following revisions have been made to this template to comply with PPACA:

**ADDENDUM – ARKANSAS PPACA APPLICATION FORMS LIST REVISION**  
**DESCRIPTION**

- Eligible Dependent section – the foster child question has been revised and the new version will be used when groups are subject to PPACA.
- Employee Agreement section - the bullet regarding misrepresentations has been revised to refer to fraud or intentional misrepresentation and will be used when groups are subject to PPACA.
- Preexisting Condition Exclusion and Special Enrollment Rights section – A new section has been added for groups that are subject to PPACA. The new section includes changes to the preexisting provision in compliance with PPACA and a section on Special Enrollment Rights for Children’s Health Insurance Program (CHIP) has been added.

**PRODUCT LIST**

Except where noted earlier in this Addendum, the forms listed in this Addendum will be used with the following previously approved Group Insurance products:

<b>Policy Form Numbers</b>	<b>Group Product Coverage</b>
GC 100 et al	Group Term Life Insurance (existing business only)
GC 1000 et al	Group Voluntary Term Life Insurance (existing business only)
GC 6000 et al	Group Term Life Insurance
GC 6000 (VTL) et al	Group Voluntary Term Life Insurance
GC 300 et al	Group Long Term Disability Insurance (existing business only)
GC 3000 et al	Group Long Term Disability Insurance
GC 400 et al	Group Short Term Disability Insurance (existing business only)
GC 4000 et al	Group Short Term Disability Insurance
GC 700 et al	Group Dental Expense Insurance (Indemnity) (existing business only)
GC 700 (PPO) et al	Group Dental Expense Insurance (PPO) (existing business only)
GC 2000 et al	Group Voluntary Dental Expense Insurance (Indemnity) (existing business only)
GC 2000 (PPO) et al	Group Voluntary Dental Expense Insurance (PPO) (existing business only)]
GC 7000 et al	Group Dental Expense Insurance
GC 7100 et al	Group Dental Expense Insurance
GC 900 et al	Group Vision Expense Insurance
GC 5000 et al	Group Medical Expense Insurance

**PRINCIPAL LIFE INSURANCE COMPANY  
STATEMENT OF VARIABILITY  
FOR PPACA AMENDMENT AND RIDER FILING  
STATE OF ARKANSAS**

**Policy Amendment GC 801 PPACA and Booklet-Certificate Rider GH 198 PPACA**

- [1] This variable will only be used for our PPO and Indemnity plans.
- [1A] Copay is bracketed as it would not be used with a High Deductible Health Plan.
- [2] Definition of Dependent; Dependent Child; Dependent Children. Our standard to allow coverage for a Dependent Child is a child less than 26. We have bracketed the age to allow flexibility should the Policyholder want to allow other children to be covered. We also would apply any required state requirements to this age limitation as necessary. However, the age will never be less than 26.
- Our age ranges for variables where we've indicated [26] will be ages 26-30
- [3] This definition will be used for large employer groups.
- [4] Definition of Dependent; Dependent Child; Dependent Children. The definition of Dependent allows for coverage for Domestic Partner coverage. This variable for Domestic Partner coverage will be used when the Policy elects to cover Domestic Partners.
- [5] This is being included to provide the required information on the Right of External Review.
- [6] This variable will be used for our PPO and HDHP plans.
- [7] This variable will be used for our Indemnity plans.



**Principal Life  
Insurance Company**

**Patient Protection and Affordable Care Act (PPACA)  
Certification of Compliance**

Company: Principal Life Insurance Company

Company FEIN: 42-0127290

I, Kimberly Douglas, an Officer of Principal Life Insurance Company hereby certify that to the best of my knowledge and belief, concerning requirements necessary to comply with federal PPACA and associated health care reform legislation, that the forms listed herein, are complete and contains all materials required by the federal PPACA.

I understand that the Arkansas Department of Insurance will rely on this Certification of Compliance for the forms listed, and should it subsequently be determined that the forms listed do not comply with federal PPACA and associated health care reform legislation or that this certification is false or incorrect; corrective and disciplinary action, including retroactive disapproval, as authorized by law, may be taken by the Department against the Company.

PRINCIPAL LIFE INSURANCE COMPANY

A handwritten signature in cursive that reads "Kimberly Douglas".

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Kimberly Douglas, Director  
Group Life and Health Compliance

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August 19, 2010

Date