Employer Application for Group Insurance - MO

Principal Life Insurance Company
Des Moines, IA 50392-0002

Principal®

PLEASE USE BLACK INK
PLEASE ENTER DATES AS MM/DD/YYYY

To avoid processing delays, please make sure you answer all questions completely and accurately. For an amendment to an existing account, if no changes are noted in the sections below, current elections will remain in effect.

This form is for: ☑ new case ☐ amendment Account number _____

Requested effective date: 01.01.2026

Employer Information (if this is an amendment, only complete information that is changing)

Legal name of company	Federal tax ID number
Christian County Government	44-6000473

DBA name (if applicable)

Physical street address	City	State	ZIP code
100 W. Church St. Rm. 100	Ozark	MO	65721

1. Is the company publicly traded or owned by a 51% majority or more by a different company that is publicly traded on a U.S. Stock Exchange? ☐ yes ☑ no
2. Is the company registered with the SEC (i.e. registered investment advisor, broker dealer), a state regulated insurance company, a U.S. federal or state regulated bank, a department or agency of the United States, or of any state? ☐ yes ☑ no
3. If the answer to Question 1 and 2 above is no, please answer the following additional questions:
   a. Is the company owned by a non-US person or foreign entity? ☐ yes ☑ no
   b. Is the company a non-governmental organization (NGO) foundation or charity? ☐ yes ☑ no
   c. Is the company a foreign financial institution? ☐ yes ☑ no
   d. Does any individual own a 25% or greater equity interest (direct ownership or beneficial owner) in the company? ☐ yes ☑ no If yes, please provide the following information for each equity interest individual:

      Name (first/middle initial/last) Date of birth Email address Phone

      _____

      _____

      _____

   e. Does any other company own a 25% or greater equity interest (direct ownership or beneficial owner) in the company? ☐ yes ☑ no If yes, please provide the following information for each equity interest company:

      Company name Company Federal Tax ID

      _____

      _____

      _____
4. Does the company do business outside of the US? ☐ yes ☑ no If yes, please check if the business is in one of the following countries: ☐ Cuba ☐ Iran ☐ North Korea ☐ Russia ☐ Syria ☐ Crimean region of Ukraine

Affiliate/Subsidiary Information (if this is an amendment, only complete information that is changing) 210

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.

Unit name/address/federal tax ID	Nature of business	Relationship to company	Number of employees
1.			
2.			

Request for Benefits (if adding new coverage(s) to an existing account, provide new proposal number)

By signing this Application form, you are confirming that you agree with all the benefit plan provisions that you are applying for as outlined in your proposal # _____. Do you agree? ☐ yes ☐ no

Employee Eligibility (if this is an amendment, only complete information that is changing)

☐ standard - An employee must work at least 30 hours per week to be eligible for insurance.

☑ other (select between 20 and 40 hours): 32

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.

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 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, you must indicate a Named Fiduciary for this plan. Principal Life may not be designated as Named Fiduciary.

- 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. 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 critical illness, hospital Indemnity, and long term disability insurance have been explained to and understood by the employer. Actively at work and period of limited activity for life, disability, critical illness, accident and hospital indemnity 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 to redistribute them from time to time thereafter as reasonably required by Principal Life.
- The provisions of this application or the policy or policies cannot be changed or waived without the written approval of an officer of Principal Life in the home office. Your insurance provider or broker does not have authority to change or waive any provisions of this application or the policy or policies.
- 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 800-388-4793 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.

Any person who, with intent to defraud or knowing that they are 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)
Christian County Government

Signed by (must be an officer)	Officer's title	Date signed
X	Presiding Commissioner	12.10.2025

Printed officer name
Lynn Morris

Signature of licensed resident insurance producer(s) (individual/firm)	Insurance producer's license number	Date signed
X		

Licensed resident insurance producers(s) printed name(s)

Signature of soliciting insurance producer(s) (If more than one, all must sign.)	Date signed
X	

Soliciting insurance producer(s) printed name(s)

For Principal Life Use Only

Addendum to Employer Application for Group Insurance

Principal Life Insurance Company
Des Moines, IA 50392-0002

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PLEASE ENTER DATES AS MM/DD/YYYY

To avoid processing delays, please make sure you answer all questions completely and accurately. Please complete this form and submit it with the Employer Application.

Account number: ______________

This form is for: ☒ new case ☐ amendment to add Life/Disability/Critical Illness/Accident/Hospital Indemnity

Life/Disability/Critical Illness/Accident/Hospital Indemnity group policies are issued with an Actively at Work provision. Employees must be Actively at Work in order to be considered eligible for coverage under the above group policy(ies); exceptions require written approval by Principal Life Insurance Company. Actively at Work means an employee must be performing the normal duties of their occupation and working their regular number of hours on regularly scheduled workdays. All employees NOT Actively at Work must be reported on this Addendum. You may exclude employees who are off work due to vacation.

If requesting life, disability, critical illness, accident, or hospital indemnity insurance, are there any employees not Actively at Work? ☐ yes ☒ no

If yes, please list employees not Actively at Work below. If you have additional employees not actively at work, please attach a separate paper.

Name of Employee	Date of birth	Date last worked	Reason for absence (include medical condition)	Anticipated date of return to work	Insured had the following prior coverage(s)	Insured has approved claim with prior carrier
					☐ Life ☐ VTL ☐ STD ☐ LTD ☐ CI ☐ Accident ☐ HI	☐ Life ☐ VTL ☐ STD ☐ LTD
					☐ Life ☐ VTL ☐ STD ☐ LTD ☐ CI ☐ Accident ☐ HI	☐ Life ☐ VTL ☐ STD ☐ LTD
					☐ Life ☐ VTL ☐ STD ☐ LTD ☐ CI ☐ Accident ☐ HI	☐ Life ☐ VTL ☐ STD ☐ LTD
					☐ Life ☐ VTL ☐ STD ☐ LTD ☐ CI ☐ Accident ☐ HI	☐ Life ☐ VTL ☐ STD ☐ LTD
					☐ Life ☐ VTL ☐ STD ☐ LTD ☐ CI ☐ Accident ☐ HI	☐ Life ☐ VTL ☐ STD ☐ LTD
					☐ Life ☐ VTL ☐ STD ☐ LTD ☐ CI ☐ Accident ☐ HI	☐ Life ☐ VTL ☐ STD ☐ LTD

Signatures

Employer (company name)
Christian County Government

Signed by (must be an officer)
X [signature]

Officer's title
Presiding Commissioner

Date signed
12.10.2025

Printed officer name
Lynn Morris