



Mailing Address:
Des Moines, IA 50392-0001

Principal Life
Insurance Company

Overhead Expense
Application Supplement

1. Proposed Insured _____ Date of Birth _____

2. Name of your business _____

Benefit Amount \$ _____

Elimination Period 30 day 60 day 90 day

Maximum Aggregate Benefit Factor 12 18 24

Optional Benefit Riders:

Residual Disability Benefit

Other _____

You *MUST* select **ONE of the following:**

Benefit Update (BU) AND
Automatic Increase Option (AIO)

Benefit Update (BU) only

Automatic Increase Option (AIO) only

Neither BU nor AIO

Owner (if other than the proposed insured) – (Please list owner below and sign Part C).

Name _____ Address _____

City _____ State _____ Zip _____ Owner Taxpayer ID Number _____

LOSS PAYEE (if other than the owner) FOR OVERHEAD EXPENSE ONLY

Name _____ Address _____

City _____ State _____ Zip _____

3. Type of business: Sole proprietorship Partnership C-Corp S-Corp
 Limited Liability Company (LLC)

4. a. Your percent of ownership _____%

b. Your share of overhead expenses _____%

c. Name(s) and ownership percentage of other owners _____

d. If other owners, do they have, or are they applying for Overhead Expense insurance?.... Yes No

If No, explain: _____



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5. a. LIST YOUR SHARE OF THE CURRENT, AVERAGE MONTHLY OVERHEAD EXPENSES

Table with 4 columns: Expense Category, Amount (\$), Expense Category, Amount (\$). Rows include Rent, Mortgage, Property taxes, Insurance premiums, Loan payments, Accounting fees, Security, Electricity, Continued education, Office supplies, Telephone, Subscriptions, Other fixed business expenses.

b. TOTAL ELIGIBLE OVERHEAD EXPENSES (Sum of Itemized Expenses above) \$ _____

6. PERSONAL SERVICE PROFESSIONALS ONLY (e.g. DOCTOR, LAWYER, CPA, etc.)

Does the business employ other individuals from your profession?..... [] Yes [] No
If Yes, how many? _____

7. List the job title, number and monthly salaries of non income producing employees. Exclude members of your profession:

Table with 3 columns: Job Title, Number of Employees, Combined Monthly Salaries (your share). Includes a Total salaries row at the bottom.

I represent that all the above statements in this application are true and complete to the best of my knowledge and belief. I understand that the statements in this application are a part of any insurance issued.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

SIGNATURES (Please do not print name below. Signatures are required.)

X _____ Signed at: City _____ State _____ / / _____ Date

X _____ / / _____ Date
Witness (Licensed Agent/Broker/Representative)