Principal Life
Insurance Company
P.O. Box 14455
Des Moines, IA 50306-3455

DI Retirement Security
Disability Insurance Application

Thank you for choosing Principal Life Insurance Company to meet your client's individual disability insurance needs.

Please follow the instructions below to expedite the application process.

General Instructions

- ☐ Complete **Part A** of the application and obtain signatures on **Part C.** Answer all questions legibly in blue or black ink. The **applicant** is required to initial any changes.

- ☐ Complete the **Producer Report** and all **supplemental forms** (if applicable).

- ☐ Call toll free **1-888-835-3277** (1-888-TELEAPP) to schedule the telephone application interview. A TeleApp counselor will ask the questions from Part B (medical/habits information) of the application. When asked about ordering underwriting requirements for you, please indicate to the TeleApp Counselor this is a **DI Retirement Security** application**;** therefore routine medical requirements (blood, urine, etc) are not required, unless specifically requested by the Underwriter.

- ☐ Submit the **Producer Report**, **Part A, Part B** (if applicable), **Part C and all supplemental forms** (if applicable). Please do not duplex the application pages and only print data and wording on one side of a page.

- ☐ Submit the signed **Declaration of Trust, Disclosure Statement, Authorization for the Exchange of Information, Irrevocable Assignment of Right to Receive Benefits,** and **Contribution Worksheet.**

- ☐ Submit the **Premium Summary Report** of the DI Illustration. Submitting this report helps expedite the underwriting process.

- ☐ If COD (Cash on Delivery) do not give the Conditional Receipt to the applicant/Proposed Insured. If money is taken with the application or if the pre-approved Payroll Deduction Form (Applicable to Multi-Life cases only) is used, then give the Conditional Receipt to the applicant/Proposed Insured.

- ☐ Provide copies of the signed Declaration of Trust, Disclosure Statement, Authorization for the Exchange of Information, Irrevocable Assignment of Right to Receive Benefits and Contribution Worksheet to the applicant.

- ☐ If multiple producers are indicated on the Producer Report (question 3, page 1) the **1st year and renewal commissions**, including contractual benefit increases such as FBI and BU, are paid per the split indicated. The producer listed on the 1st line in the box indicating **Servicing Producer,** is designated to provide policy service and receive all applicable service correspondence sent to the client. To change the **recipient of commissions** for new adjusted coverage and subsequent contractual increases such as FBI and BU, an **Agent of Record Change** is required and should be submitted to Marketer Services.

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DI Retirement Security Producer Report

Proposed Insured _____ Policy Number _____

1. Office Contact Information – Whom should we contact during the processing of this application?

Field Case Contact	Contact's Phone Number	Contact's Email Address

2. Producer and Field Office Information

Field Office Name	Principal Field Office Number	Producer's Phone Number

3. Compensation Information

List all Producers to Receive Compensation	Tax ID Number	Statement/ Detail Code	Commission Split % must equal 100
Primary Servicing Producer (receives correspondence)			
If producer is signing for Corp/Non Corp, reference signing producer's tax ID			

4. Additional Information

a. Discounts (check those that apply)

☐ Multi-Life (List Bill – requires three or more lives)
- ☐ Existing List Bill Number (if known) _____
- ☐ New List Bill _____

Employer's Name _____
Employer's Address _____
_____
Employer Tax ID _____
Initial Billing sent to ☐ Producer ☐ Employer

☐ Association (If approved in your state)
Association Name _____
Association Number _____

☐ Mental/Nervous

☐ Select Occupation

b. Occupation Class Quoted: ☐ 5A ☐ 5A-M ☐ 4A ☐ 4A-M ☐ 3A ☐ 3A-M ☐ 2A ☐ A

c. Send premium notices to (if other than the owner) _____
_____

d. Proposed Insured's relationship to the Producer/Licensed Representative _____

e. Is English the Proposed Insured's primary language?..... ☐ Yes ☐ No
(If No, submit Statement of English Understanding form)

f. If special dating is essential, indicate policy date desired: ___/___/_____ . If money is taken with application, no requests for advance dating honored except to conform with established Electronic Funds Transfer date.

g. Are funds being submitted with the application? ☐ Yes ☐ No; If Yes, what is the amount? $ _____

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DI Retirement Security Producer Report

Proposed Insured _____ Policy Number _____

4. Additional Information (Continued)

h.

Product	Payment Mode	Mode Premium	Total Annual Premium
	/	/	/
	/	/	/
	/	/	/
	/	/	/

i. Comments or special instructions _____

5. Agent/Broker/Licensed Representative Signature

☐ This application was signed by the applicant in my presence.

☐ I was not present at the time this application was signed by the applicant.

The answers to each question of this application were recorded exactly as given. I have recorded all known risk information on this application. I request distribution of commissions as indicated in this Producer Report.

I gave the Customer (Owner) a copy of the **'Disclosure of Compensation Statement'** form if applicable and/or obtained the **'Compensation and Relationship Disclosure Statement'** (required for sales by Principal Life Proprietary Agent) as applicable prior to/at the time the Customer (Owner) signed the application.

Agent/Broker/Licensed Representative Signature	Signed at: City	State	Zip	Date
X				/ /

Principal Life Insurance Company
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Des Moines, IA 50306-3455

Disability Insurance Application – PART A

1. Personal Information about the Proposed Insured

Name (First, Middle, Last)			Gender ☐ Male ☐ Female	Date of Birth / /
Street Address			Social Security Number - -	State of Birth (Country, if other than U.S.)
City	State	Zip	Home Phone Number ( )	Work Phone Number ( )
Occupation/Duties			Driver's License Number	Driver's License State Issued

Have you smoked cigarettes or used a nicotine patch or gum within the past 12 months? ..... ☐ Yes ☐ No
Are you a U.S. citizen? ☐ Yes ☐ No If no, submit Confidential Non-US Citizen Questionnaire.

2. Indicate Coverage(s) Applying For

- ☐ **Disability Income** (Complete Sections 3-7 and Part C)
- ☐ **Overhead Expense** (Complete Sections 4-7, Part C, and the *Overhead Expense* Application Supplement)
- ☐ **Disability Buy-Out** (Complete Sections 4-7, Part C, and the *Buy-Out* Application Supplement)
- ☐ **DI Retirement Security** (Complete Sections 4-7, Part C, and the *DI Retirement Security* Application Supplement)
- ☐ **Key Person Replacement** (Complete Sections 4-7, Part C, and the *Key Person* Application Supplement)

3. Disability Income

Monthly Benefit Amount: $ _____

Elimination Period:	☐ 30 day	☐ 60 day	☐ 90 day	☐ 180 day	☐ 365 day
Benefit Period:	☐ 2 year	☐ 5 year	☐ to age 65	☐ to age 67	☐ to age 70
Your Occupation Period:	☐ 2 year	☐ 5 year	☐ to age 65	☐ to age 67	☐ to age 70

SIS Monthly Benefit: $ _____ SIS Benefit Period must equal Base Benefit Period.

SIS Elimination Period:	☐ 30 day	☐ 60 day	☐ 90 day	☐ 180 day	☐ 365 day

Adaptable Income Benefits (AIB) **Note: AIBs program monthly benefits around other in-force coverage**

1st AIB Monthly Benefit: $ _____ from day _____ to day _____
2nd AIB Monthly Benefit: $ _____ from day _____ to day _____
SIS AIB Monthly Benefit: $ _____ from day _____ to day _____

Optional Benefit Riders

- ☐ Catastrophic Disability Benefit (CDB) Monthly Amount: $ _____
  - CDB Elimination Period: ☐ 90 day ☐ 180 day ☐ 365 day
  - CDB Benefit Period: ☐ 2 year ☐ 5 year ☐ to age 65 ☐ to age 67 ☐ to age 70
- ☐ Cost of Living Adjustment: ☐ 3% max ☐ 6% max
- ☐ Extended Total Disability Benefit
  - Aggregate Benefit Factor: ☐ 50 ☐ 75 ☐ 100
- ☐ Recovery Benefit: ☐ 1 year ☐ 3 year
- ☐ Regular Occupation
- ☐ Residual Disability Benefit
- ☐ Short Term Residual Disability Benefit: ☐ 6 month ☐ 12 month
- ☐ Other _____

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

- ☐ Benefit Update (BU) AND Future Benefit Increase (FBI)
- ☐ Benefit Update (BU) only
- ☐ Future Benefit Increase (FBI) only
- ☐ Neither BU or FBI

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Disability Insurance Application – PART A

Proposed Insured _____ Policy Number (if known) _____

3. Disability Income (Continued)

Premium Discounts

☐ Multi-Life

☐ Mental/Nervous ☐ Select Occupation ☐ Association

Owner (if other than Proposed Insured) – (Please list owner below and sign Part C.)

Name _____ Address _____

City _____ State _____ Zip _____ Owner Taxpayer ID Number _____

Benefit Recipient (if other than Owner) for Disability Income Only

Name _____ Address _____

City _____ State _____ Zip _____

4. Premium Payer and Method of Payment

a. Premium paid by: ☐ Proposed Insured ____ % ☐ Employer ____ %

b. If your employer pays any part of the premium, is it reportable by you as taxable income? ..... ☐ Yes ☐ No

c. Premium Mode: ☐ Annual ☐ Semi Annual* ☐ Quarterly* ☐ Monthly EFT*

* There is an additional charge for premium payment frequencies other than annual.

5. Other Disability Insurance

Do you have, are you applying for, or will you become eligible for in the next three years (based on a qualifying period of employment), any other Disability Insurance?..... ☐ Yes ☐ No

If Yes, please list below any Disability Income (listing any Catastrophic or Lifetime Benefits separately), Group Disability, Association, State Disability, Retirement/Pension, Overhead Expense, Disability Buy-Out, Key-person, Salary Continuation or Short Term Contingency Disability Insurance. Also include any policies that include disability benefits provided under Accident or Sickness insurance, Pension, Retirement, Credit Insurance plans, or Loan Protection coverage.

Company	Policy No.	Type of Coverage	Benefit Amt. or % of Income	Elim. Period	Benefit Period	Ind. Pay (I) Emp. Pay (E)	Pending Yes	Pending No	Replacing Yes	Replacing No
						☐ I ☐ E	☐	☐	☐	☐
						☐ I ☐ E	☐	☐	☐	☐
						☐ I ☐ E	☐	☐	☐	☐
						☐ I ☐ E	☐	☐	☐	☐

Replacement: By signing this application, I agree to terminate the insurance policy(s) that I indicated above as being replaced within 60 days of the acceptance of this policy. I understand that if I do not cancel or lapse the insurance policy(s), Principal Life Insurance Company has the right to rescind (terminate as if never issued) any policy issued as a result of this application.

Principal Financial Group

Principal Life Insurance Company
P.O. Box 14455
Des Moines, IA 50306-3455

Disability Insurance Application – PART A

Proposed Insured _____ Policy Number (if known) _____

6. Financial

a. **Unearned Income** – Includes capital gains, interest, dividends, net rental income, pensions, annuities, and alimony. Is unearned income greater than 10% of earned income, or $30,000?..... ☐ Yes ☐ No

If Yes, itemize: _____

b. **Net Worth** – Is net worth, excluding primary residence, greater than $6,000,000? ..... ☐ Yes ☐ No

If Yes, itemize: _____

	Tax Year:	Current Year _____	Last Yr. _____	2 Yrs Ago _____
c.	**Earned Income** – Income as shown on Federal Income Tax Return:	Current YTD Income	Income Last Yr.	Income 2 Yrs Ago
c1.	Owner or Nonowner Employee's salary & bonus, (FormW-2). (less business expenses reported on IRS Form 2106)	$ _____	$ _____	$ _____
c2.	Owner-Employee's share of after-tax corp profits or losses (after expenses) (minimum 20% active owner) (Form 1120 or 1120S)	_____	_____	_____
c3.	Sole Proprietor net income, after expenses (Form 1040, Schedule C)	_____	_____	_____
c4.	Share of Partnership or LLC net income, after expenses (Schedule K-1 or Form 1040, Schedule E)	_____	_____	_____
c5.	Pension plan or Profit-Sharing contributions made on your behalf, by a business you own	_____	_____	_____
c6.	Total Earned Income: Sum of (c1) thru (c5) for each year	$ _____	$ _____	$ _____

If using Traditional application process, stop here and proceed to Part B (pages 4-7).

7. Medical Question

a. Within the last five years, have you ever been treated by a member of the medical profession, or been diagnosed by a member of the medical profession as having a heart condition, chest pain, stroke, back or neck problem, psychological condition (including, but not limited to, counseling from a mental health or substance abuse provider, and/or psychotherapy), cancer, diabetes, alcohol abuse, or drug dependency?..... ☐ Yes ☐ No

If Yes, provide details in the Comments below, including dates and healthcare provider's name and address.

b. Current Height _____ Weight _____ Have you lost more than 10 lbs. in the last year?..... ☐ Yes ☐ No

Comments: _____

If using Teleapp, proceed to Part C (page 8).

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Disability Insurance Application – PART C

Proposed Insured _____

Agreement/Authorization to Obtain and Disclose Information.

("Company" means Principal Life Insurance Company)

AGREEMENT: Statements In Application(s): I represent that all statements in this application(s) are true and complete to the best of my knowledge and belief and were correctly recorded before I signed my name below. I understand and agree that the statements in this application(s), including all of its parts, and statements by the Proposed Insured in any medical questionnaire(s) that becomes a part of this application(s), will be the basis of any insurance issued. I understand that misrepresentations could mean denial of an otherwise valid claim and rescission of the policy during the contestable period.

When Insurance Effective: I understand and agree that the Company shall incur no liability unless: (1) a policy issued on this application(s) has been received and accepted by the owner and the first premium paid; and (2) at the time of such receipt and payment, the person to be insured is actually in the state of health and insurability represented in this application(s), medical questionnaire(s), or amendment(s) that becomes a part of this application(s); and (3) the Part D of the completed Tele-App interview or the Delivery Receipt form is signed by me and the Proposed Insured (if different) and dated at delivery. If these conditions are met, the policy is deemed effective on the Policy Date stated in the policy.

Limitation of Authority: I understand and agree that no agent, broker, licensed representative, telephone interviewer, or medical examiner has any authority to determine insurability, or to make, change, or discharge any contract, or to waive any of the Company's rights. The Company's right to truthful and complete answers to all questions on this application(s) and on any medical questionnaire(s) that becomes a part of this application(s) may not be waived. No knowledge of any fact on the part of any agent, broker, licensed representative, telephone interviewer, medical examiner, or other person shall be considered knowledge of the Company unless such fact is stated in the application(s).

☐ This application(s) is Cash on Delivery (C.O.D.); and no Conditional Receipt coverage is provided, or

☐ I have paid $ _____ for Disability Income/$ _____ for Overhead Expense/$ _____ for Disability Buy-Out/$ _____ for Key Person Replacement insurance which is no less than one month's advance premium. If money was paid, I have been given the Conditional Receipt. In return I have read, understand, and agree to its terms, or

If preapproved by Principal Life Insurance Company:

☐ I have signed, dated and submitted to the Company one of the three documents listed below in this box. I have been given the Conditional Receipt. In return I have read, understand, and agree to its terms.

- Payroll Deduction Authorization Form
- Employer Pay Form
- Other form acceptable to the Company

(continued on next page)

Principal Life Insurance Company
P.O. Box 14455
Des Moines, IA 50306-3455

Proposed Insured _____

(continued from previous page)

Agreement/Authorization to Obtain and Disclose Information

AUTHORIZATION: I authorize any insurance (or reinsuring) company, consumer reporting agency, governmental agency, insurance agent, broker, licensed representative, or any other organization, institution, or person having personal information (including physical, mental, drug, or alcohol use history) regarding the named Proposed Insured to provide to the Company, its representatives, or reinsurers, any such data. I authorize the Company to conduct a telephone interview in connection with my application(s) for insurance.

I authorize the Medical Information Bureau, Inc. (MIB, Inc.) to furnish data to the Company or its reinsurers. I authorize Principal Life to release any such data to MIB, Inc. or as required by law. Notwithstanding any other provision in this form, the authorization to release data to the MIB, Inc. shall survive the termination of this form to the extent necessary to confirm, correct, or update previously supplied data to the MIB, Inc. Data released may include results of my medical examination or tests requested by the Company. I understand that the data obtained by use of this authorization will be used by the Company to determine eligibility for insurance.

I have received a copy of the "Notice of Insurance Information Practices," which includes all summaries and notices required by any Fair Credit Reporting Act. The Notice describes, among other things, the nature of an investigative consumer report and the scope of the information it may contain. The Notice also describes MIB, Inc. I agree that this authorization shall be valid for 24 months from the earlier of: (1) the date of this application(s), or (2) the date of my policy. I may revoke this authorization for information not then obtained. Such revocation must be in writing. It will not be effective until received at the Company's Home Office. I agree that a photocopy of this authorization is as valid as the original. I have received a copy of this authorization.

Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

SIGNATURES (Please do not print name below. **Signatures, City, State and Date are required.**)

Proposed Insured **X**	Signed at: City	State	Date / /
Disability Income; Owner (If other than Proposed Insured) **X**	Title (If Corporation, Officer other than Proposed Insured)		Date / /
Overhead Expense; Owner (If other than Proposed Insured) **X**	Title (If Corporation, Officer other than Proposed Insured)		Date / /
Disability Buy-Out; Owner **X**	Title (If Corporation, Officer other than Proposed Insured)		Date / /
Key Person Replacement; Owner **X**	Title (Officer other than Proposed Insured)		Date / /
Agent/Broker/Licensed Representative **X**	License Number		Date / /
Co-signature by Resident Licensed Rep. (If applicable in your state) **X**	License Number		Date / /

Principal Life Insurance Company
P.O. Box 14455
Des Moines, IA 50306-3455

Disability Insurance Application – PART C

Agreement/Authorization to Obtain and Disclose Information.

("Company" means Principal Life Insurance Company)

AGREEMENT: Statements In Application(s): I represent that all statements in this application(s) are true and complete to the best of my knowledge and belief and were correctly recorded before I signed my name below. I understand and agree that the statements in this application(s), including all of its parts, and statements by the Proposed Insured in any medical questionnaire(s) that becomes a part of this application(s), will be the basis of any insurance issued. I understand that misrepresentations could mean denial of an otherwise valid claim and rescission of the policy during the contestable period.

When Insurance Effective: I understand and agree that the Company shall incur no liability unless: (1) a policy issued on this application(s) has been received and accepted by the owner and the first premium paid; and (2) at the time of such receipt and payment, the person to be insured is actually in the state of health and insurability represented in this application(s), medical questionnaire(s), or amendment(s) that becomes a part of this application(s); and (3) the Part D of the completed Tele-App interview or the Delivery Receipt form is signed by me and the Proposed Insured (if different) and dated at delivery. If these conditions are met, the policy is deemed effective on the Policy Date stated in the policy.

Limitation of Authority: I understand and agree that no agent, broker, licensed representative, telephone interviewer, or medical examiner has any authority to determine insurability, or to make, change, or discharge any contract, or to waive any of the Company's rights. The Company's right to truthful and complete answers to all questions on this application(s) and on any medical questionnaire(s) that becomes a part of this application(s) may not be waived. No knowledge of any fact on the part of any agent, broker, licensed representative, telephone interviewer, medical examiner, or other person shall be considered knowledge of the Company unless such fact is stated in the application(s).

☐ This application(s) is Cash on Delivery (C.O.D.); and no Conditional Receipt coverage is provided, or

☐ I have paid $ _____ for Disability Income/$ _____ for Overhead Expense/$ _____ for Disability Buy-Out/$ _____ for Key Person Replacement insurance which is no less than one month's advance premium. If money was paid, I have been given the Conditional Receipt. In return I have read, understand, and agree to its terms, or

If preapproved by Principal Life Insurance Company:

☐ I have signed, dated and submitted to the Company one of the three documents listed below in this box. I have been given the Conditional Receipt. In return I have read, understand, and agree to its terms.

- Payroll Deduction Authorization Form
- Employer Pay Form
- Other form acceptable to the Company

AUTHORIZATION: I authorize any insurance (or reinsuring) company, consumer reporting agency, governmental agency, insurance agent, broker, licensed representative, or any other organization, institution, or person having personal information (including physical, mental, drug, or alcohol use history) regarding the named Proposed Insured to provide to the Company, its representatives, or reinsurers, any such data. I authorize the Company to conduct a telephone interview in connection with my application(s) for insurance.

I authorize the Medical Information Bureau, Inc. (MIB, Inc.) to furnish data to the Company or its reinsurers. I authorize Principal Life to release any such data to MIB, Inc. or as required by law. Notwithstanding any other provision in this form, the authorization to release data to the MIB, Inc. shall survive the termination of this form to the extent necessary to confirm, correct, or update previously supplied data to the MIB, Inc. Data released may include results of my medical examination or tests requested by the Company. I understand that the data obtained by use of this authorization will be used by the Company to determine eligibility for insurance.

I have received a copy of the "Notice of Insurance Information Practices," which includes all summaries and notices required by any Fair Credit Reporting Act. The Notice describes, among other things, the nature of an investigative consumer report and the scope of the information it may contain. The Notice also describes MIB, Inc. I agree that this authorization shall be valid for 24 months from the earlier of: (1) the date of this application(s), or (2) the date of my policy. I may revoke this authorization for information not then obtained. Such revocation must be in writing. It will not be effective until received at the Company's Home Office. I agree that a photocopy of this authorization is as valid as the original. I have received a copy of this authorization.

Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

Principal Life Insurance Company
P.O. Box 14455
Des Moines, IA 50306-3455

Disability Insurance Conditional Receipt

(In this Conditional Receipt (Receipt), "we", "us", "our", or "the Company" is Principal Life Insurance Company.)

Name of Proposed Insured

Advance payment of: (Disability Income) $ _____ (Overhead Expense) $ _____ (Disability Buy-Out) $ _____ (Key Person) $ _____

has been received this date as a premium deposit with the application(s) bearing the same date as this Receipt.

Agent/Broker/Licensed Representative

Date of Receipt ___ / ___ / _____

Authority:

This Receipt is not a "binder." No agent, broker, licensed representative, medical examiner, or telephone interviewer may accept risks, determine insurability, or bind the Company in any way. No agent, broker, or licensed representative may waive or change any terms of the Receipt, or of the policy(ies) applied for, or any other rights of the Company.

The agent, broker, or licensed representative has **NO AUTHORITY** to accept any premium or to issue this Receipt if it is apparent that any **Condition Precedent** to coverage under this Receipt is not or cannot be satisfied. **This Conditional Receipt shall be ineffective if issued without authority. Only the Home Office, and not the agent, broker, or licensed representative, has authority to modify any provisions of this Receipt.**

Insurance Provided:

If all of the **Conditions Precedent** set forth in this Receipt are fulfilled exactly, insurance under this Receipt takes effect on the **Start Date**. The Start Date is the date upon which all of our initial application(s) requirements are completed. Our initial application(s) requirements consist of full completion and signing of the application(s) (Parts A and C, if using the telephone application(s) process; Parts A, B, & C, if using the paper application(s) process) and all necessary supplements, and any medical exams and tests required by our published rules.

The insurance provided by this Receipt shall be the lesser of the amount applied for on this application(s) or the amount set forth in the **LIMITATIONS** section of this Receipt, subject to all the **LIMITATIONS** set forth in this Receipt. Any insurance provided by this Receipt ends on the **Stop Date**, which is the **earliest** of:

(a) 75 days after the Start Date;

(b) the date we mail the premium payer a premium refund and the proposed owner a notice that we will not consider the application(s) on a prepaid basis;

(c) the date we mail the premium payer a premium refund and the proposed owner a notice that no policy(ies) will be issued on the application(s);

(d) the date a policy(ies) is presented to the proposed owner (whether or not accepted by the proposed owner).

This Receipt does not commit us to issue any policy(ies). However, in determining whether to issue a policy(ies) and on what terms, we will consider no changes in the Proposed Insured's health or insurability occurring between the Start Date and the Stop Date. We have until the actual delivery of the policy(ies) to make this determination. If an event giving rise to a claim occurs at any time before physical delivery and acceptance of a policy(ies) by the owner, the claim will be considered solely under this Receipt even if a policy(ies) is issued. If any provision of this Receipt is unenforceable under state law, all other terms and conditions shall continue in full force and effect.

Conditions Precedent if a premium deposit is submitted with this application(s):

All the following conditions must be fulfilled exactly. Otherwise there is NO insurance under this Receipt and the Receipt is void:

1. On the Start Date, the Proposed Insured must be insurable, as determined by our underwriters under our underwriting guidelines then in effect. If a condition affecting such insurability existed in fact on the Start Date, it shall be considered in the determination of insurability.
2. All statements of material fact are included in Part(s) A, B, and C of this application(s), any supplemental form(s), and medical questionnaire(s) that become part of the policy(ies) and such statements are correct, true, and complete.
3. The premium deposit must be at least one full month's premium for each policy(ies) applied for.
4. The premium deposit must be paid at the time this application(s) is signed, and this Receipt must be issued at the same time.
5. The premium deposit must be received in our Home Office and must be honored on first presentation for payment.

--CONTINUED--

Conditions Precedent if no premium deposit is submitted with this application(s):

All the following conditions must be fulfilled exactly. Otherwise there is NO insurance under this Receipt and the Receipt is void:

1. On the Start Date, the Proposed Insured must be insurable, as determined by our underwriters under our underwriting guidelines then in effect. If a condition affecting such insurability existed in fact on the Start Date, it shall be considered in the determination of insurability.
2. All statements of material fact are included in Part(s) A, B, and C of this application(s), any supplemental form(s), and medical questionnaire(s) that become part of the policy(ies) and such statements are correct, true, and complete.
3. Documentation authorizing payment of premiums, which is acceptable to the Company, must be signed, dated, and submitted with this application(s), and this Receipt must be issued at the same time.
4. Documentation authorizing payment of premiums and acceptable to the Company must be received in our Home Office.

Limitations:

1. Except as limited by this Receipt, our liability is governed by the terms of the policy(ies) including but not limited to all policy(ies) riders and endorsements.
2. No benefit is payable under this Receipt and this Receipt is void, if there is any incorrect, untrue, incomplete, or omitted statement of material fact in Part A, B, or C of the application(s), any supplemental form, or medical questionnaire(s) that becomes a part of the policy(ies). No knowledge of any fact on the part of any agent, broker, licensed representative, medical examiner, telephone interviewer, or other person shall be considered knowledge of the Company unless such fact is stated in the application(s).
3. **Disability Income, Catastrophic Disability Benefit, Overhead Expense, Business Loan Protection Benefit, Disability Buy-Out or Key Person Replacement –** For any claim that occurs at any time after the Start Date and before physical delivery and acceptance of a policy(ies) by the owner, any Disability Income, Catastrophic Disability Benefit, Overhead Expense, Business Loan Protection Benefit, Disability Buy-Out or Key Person maximum benefit payable will be the lesser of:
    - The amount of benefits applied for in the application(s);
    - The amount of benefits that would be offered subject to our then current underwriting guidelines and practices; or
    - $5,000 per month (Disability Benefit and Social Insurance Substitute Benefit); $5,000 per month (Overhead Expense Benefit); $5,000 per month (Business Loan Protection Benefit); $2,500 per month (Catastrophic Disability Benefit); $2,500 per month and $200,000 Lump Sum (Key Person Replacement Benefit); $500,000 (Disability Buy-Out Maximum Aggregate Benefit).

    The coverage available under the Conditional Receipt, such as the elimination period, the benefit period, the policy(ies), policy(ies) riders, and riders related to exclusions, limitations, modifications, or enhancements of coverage will be based on what we would have approved or offered to you subject to our then current underwriting guidelines and practices.

Premiums:

If a policy(ies) is issued from this application(s) bearing the same date as this Receipt, and the policy(ies) is accepted by the proposed owner, we will apply the premium deposit to the first premium due for such policy(ies). If no policy(ies) is put in force but a benefit is paid under this Receipt, we will keep the earned portion of the premium deposit and refund the balance, if any, to the premium payer. If no policy(ies) is put in force and no benefit is paid or if a policy(ies) is issued differently then applied for that results in a premium refund, the premium deposit or excess premium will be refunded to the premium payer. If this Receipt is issued for more than one type of insurance, the provisions of this paragraph shall apply separately with respect to each type.

ALL PREMIUM CHECKS MUST BE MADE PAYABLE TO PRINCIPAL LIFE INSURANCE COMPANY – DO NOT MAKE CHECKS PAYABLE TO THE AGENT/BROKER/LICENSED REP. OR LEAVE THE PAYEE BLANK.

Principal Life Insurance Company
P.O. Box 14455
Des Moines, IA 50306-3455

DI Retirement Security Application Supplement

1. Proposed Insured (please print First, Middle, Last name): _____
2. Date of Birth: ___ / ___ / _____
3. Monthly Benefit Amount applied for: $ _____
4. Elimination Period: ☐ 180 day ☐ 365 day
5. Benefit Period: ☐ to age 65 ☐ to age 67 ☐ _____
6. Your Occupation Period: ☐ 2 Year ☐ 5 Year ☐ to age 65 ☐ to age 67 ☐ _____
7. Optional benefit riders available for DI Retirement Security:
   - ☐ Future Benefit Increase Option
   - ☐ Cost of Living Adjustment: ☐ 3% max ☐ 6% max
   - ☐ Other: _____

Principal Life Insurance Company's *DI Retirement Security* is issued as a non-cancellable, guaranteed renewable, individual disability income insurance policy. *DI Retirement Security* is not a Pension or Retirement Program or a substitute for such a program.

DI Retirement Security is meant to replace only that portion of your income which would have otherwise been invested for retirement savings.

Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

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.

SIGNATURES (Please do not print name below. **Signatures, City, State and Date are required.**)

Owner *(Signature)* (Must be same as Proposed Insured) **X**	Signed at: City	State	Date / /
Witness (Agent/Broker/Licensed Representative) **X**	Date / /		

The Principal Life Insurance Company and Bankers Trust Company are precluded from the practice of law. The Company provides this sample document as a service to its clients, but makes no representations about the legal or tax consequences of the execution of this document. This form will not be appropriate to all circumstances. Prior to execution, this **irrevocable** trust instrument should be reviewed by independent legal counsel.

I, _____ ("Grantor") of _____ (city, state), hereby declare and create this Trust and deliver to Bankers Trust Company, an Iowa based bank with headquarters located at 665 Locust Street, Des Moines, Iowa, 50309 ("Trustee") as Trustee, specific rights and interests (as set forth herein and in the Irrevocable Assignment of Right to Receive Benefits which I ("Me", "My" and "Myself") have previously executed) in the Disability Income Insurance Policy which may be issued as a result of My application of _____ (Date) for a Disability Income Insurance Policy (the "Policy") (or any amendment thereto) to Principal Life Insurance Company, an Iowa corporation with headquarters located at 711 High Street, Des Moines, Iowa, 50309 ("Principal Life "). The Policy, together with such other property as may be added to this Trust, shall be held in accordance with the following Trust terms:

1. This Trust is irrevocable and I hereby waive the power to alter, amend, or modify this Trust, either alone or in conjunction with another person, except that the Grantor and the Trustee may agree to amend the fees schedules set out in paragraph 17 of this Trust. The Trustee may amend this Agreement at any time by written instrument, provided that such amendment is in the Trustee's opinion, required by applicable law or regulations. Copies of the amended Trust shall be sent to the Grantor by the Trustee or its designee no less than 60 days prior to the effective date of such change set out in the amended Trust (which shall be effective irrespective of when or whether such copy is received by the Grantor).
2. Immediately upon My becoming eligible to receive disability benefits as defined in the Policy, this Trust shall receive those benefits as proceeds of the Policy.
3. During the term of this Trust, if this Trust receives disability benefits as proceeds of the Policy, the Trustee shall invest and reinvest those proceeds. Any income earned by this Trust shall be added to principal for reinvestment. The Grantor or any other person may make additional cash contributions to the Trust, but only if the Trust has been activated and the Policy is making contributions to the Trust.
4. The Trustee shall invest the assets of this Trust in accordance with the investment objective selected by Me or My designee at the time I become eligible to receive benefits under the terms of the Policy. If I make no selection the Trustee shall invest the assets in such manner as in its discretion it deems to be appropriate.
5. In the event that the Trust has been activated, the Trustee shall provide Me with quarterly statements of the principal and income transactions in this Trust.
6. If any of the disability benefits received by the Trust and/or the income earned by the Trust is deemed to be taxable to Me, upon My written request, the Trustee may reimburse Me for the income taxes due as a result of said disability benefits and/or income earned by the Trust. Reimbursements will be deducted from Trust income and, if necessary, the principal balance. The Trustee may rely on information provided by Myself or My legal representative as to the amount of tax to be reimbursed from the Trust to the Grantor.
7. The validity, construction and effect of this instrument, the administration of the Trust, and the rights and obligations of all beneficiaries and the Trustee shall be governed by the laws of the State of Iowa.
8. In the administration of this Trust, the Trustee shall have all powers available to it under Iowa law and in addition thereto, may exercise the fiduciary powers enumerated and governed by the laws of Iowa now or hereafter in force, or any successor statute. All disputes will be governed by Iowa law.

9. The Trustee shall also have the power to employ the services of other departments or divisions of the corporate trustee, any affiliate of the corporate trustee, or non-affiliated third parties in connection with the performance of its duties hereunder, including, but not limited to, effecting securities transactions through an affiliated or non-affiliated broker dealer. The Trustee may also purchase insurance, annuity contracts, or mutual funds through an affiliated or non-affiliated agency. These insurance or annuity contracts and mutual funds may include, but not be limited to, offerings of the Principal Life Insurance Company and/or its affiliates. The Grantor understands that the corporate trustee, its affiliates or non-affiliated third parties may receive commissions for services rendered which includes a profit and the Grantor specifically authorizes the corporate Trustee to undertake such transactions on behalf of the trust estate and to pay such fees or commissions from the trust estate so long as the transactions and such fees and commissions are reasonable.

10. It is My intention that this trust qualify as a "Grantor Trust" as determined by rules contained in Sections 671 through 679 of the Internal Revenue Code.

11. During the term of this Trust, I may make a written request that the Trustee authorize an early distribution in whole or in part from this Trust. My written request to the Trustee shall set forth with reasonable specificity the grounds upon which I am requesting said early distribution. The Trustee shall have the authority and discretion to distribute some or all of the income and/or principal to Me in order to meet certain identified financial "hardships." If I should request a distribution due to "hardship" the Trustee shall, in its sole discretion, determine (i) if the distribution is necessary in light of My immediate and substantial financial needs if any, and (ii) if the funds are reasonably available from My other resources.

    a. As guidance in determining if the distribution is necessary in light of My immediate and substantial financial needs, the following criteria shall be considered:

        - Extraordinary medical or health care expenses incurred by Me or My spouse or My dependents and not covered by insurance, which may be evidenced by submitting EOB's (Explanation of Benefits).
        - Payments of amounts necessary to prevent My eviction from My principal residence or from foreclosure on its mortgage, which may be evidenced by submitting an eviction or foreclosure documents.
        - Payment of post-secondary education and related educational fees (including room and board), for Myself, My spouse, or for any of My dependents, which may be evidenced by submitting proof of expenses incurred.

    b. In determining whether funds are not reasonably available from My other resources, this requirement may be met if the following circumstances exist:

        - I have exhausted all assets from any stock portfolios, mutual funds, brokerage accounts and savings accounts owned by Me or My spouse; and have received all benefits from any individual or employer-sponsored medical plans covering Me, My spouse or My dependents.

    c. After giving due consideration to the above criteria, the Trustee, in its sole discretion, may comply with the request for early distribution in whole or in part or not at all. Under no circumstances shall any early "hardship" distribution exceed the amount of My immediate substantial financial needs.

12. If in the sole discretion of the Trustee this Trust is of insufficient size to warrant continued administration, the Trustee may purchase a single premium tax-deferred annuity payable which shall not become payable until I reach age 59 ½. The Trustee shall distribute the annuity to Me as soon as practical after I reach age 59 ½.

13. If the Grantor has not been eligible to receive benefits under the terms of the Policy for 12 consecutive months, the Grantor may make written request for total distribution in whole of the Trust assets. If assets are distributed in full because of this provision, and the balance of the Trust is zero ($0.00), the Trust goes into an inactive status, and the Trust fees are waived.

14. If the Policy contains a future purchase option rider, and if I choose to exercise the option, the additional benefit amounts shall be received, invested and administered in accordance with all the terms and conditions of this Trust.

15. This Trust shall terminate on My age 65th or age 67th policy anniversary (depending on the Benefit Period purchased and in accordance to the Policy) or upon My death if I die before reaching age 65. As soon as is practical after termination, the Trustee shall distribute the then principal and accumulated income to Me or to My estate.

16. The Trustee may resign upon one hundred and twenty (120) days written notice to Me or to My legal representative. In the event that the Trustee resigns, the Grantor and the Trustee both grant to Principal Life the power to appoint a Successor Trustee who shall have the same powers and duties as those conferred upon the Trustee hereunder. The Successor Trustee must accept such appointment in writing for the appointment to become valid, at which point only will the Trustee's appointment as such be considered to have terminated and the Successor Trustee shall become the Trustee under this Trust. Principal Life shall provide a copy of the Successor Trustee's written acceptance to the Grantor and the Trustee.

17. The Trustee shall be entitled to a fee for its services and reimbursement of its expenses. Fees will not be assessed to the Trust until Principal Life begins making payments of disability benefits to the Trust. When disability benefits payments to the Trust commence, the Trust may be assessed certain specified fees as described herein in connection with Trust administration and investment management. Under some circumstances as described herein, the Trust may be assessed an Annuity Custodial Fee.

When fees are assessed, they will be paid first from the monthly benefits paid to the Trust, then secondly from Trust income and then finally from Trust principal.

The types of fees which may be assessed are as follows:

- Administration Fee – The administration fee is made in consideration of the administrative functions of the Trustee. The administration fee will be $50 per month.
- Annuity Custodial Fee – The Annuity Custodial Fee may be assessed in certain specific circumstances if monthly disability benefits are only paid for a limited time period. If you are totally disabled for a limited time period, disability benefits payments to the Trust would cease when you are no longer totally disabled. In this situation, the Trustee in the exercise of its fiduciary duty may determine that the corpus of the Trust will not generate enough income to pay the applicable fees and also that the fees would reduce the amount of Trust principal. Upon making that determination, the Trustee shall give you the following options:

  a. to continue the Trust as is, allowing you to pay all or some of the fees or to contribute additional funds voluntarily to the Trust; or

  b. to instruct the Trustee to purchase a Single Premium Deferred Annuity (SPDA) with the Trust as the owner. The Trustee has a fiduciary responsibility to select an annuity, to perform due diligence on an ongoing basis, and to assure that legally required care of the annuity is provided. Prior to purchasing the SPDA, the Trustee will assess a one-time advance fee for the ongoing performance of its duties as follows:

Years remaining (or any part thereof) until The Grantor/Insured reaches age 59	Fee
0 – 5	$0
6 – 10	$100
11 – 15	$200
16 – 20	$300
21 – 25	$400
Over 25	$500

18. No bond shall be required of any person, bank, or trust company serving as Trustee hereunder.

19. Neither Grantor nor any payee appointed by Grantor may pledge, assign, hypothecate or alienate any interest hereunder. To the extent permissible under applicable law, no part of the income or principal of the property held under this trust shall be subject to attachment, levy or seizure by any creditor, spouse, assignee or trustee or receiver in bankruptcy of Trustor prior to his or her actual receipt thereof. Trustee shall pay over the net income and/or principal to the parties herein designated, as their interest may appear, without regard to any attempted anticipation, pledging or assignment by any beneficiary of the trust, and without regard to any claim thereto or attempted levy, attachment, seizure or other process against said beneficiary.

20. The Policy that is used in conjunction with this “DI Retirement Security” program contains several “Other Benefits” that you can add to your policy or be eligible to collect. These “Other Benefits” will be paid to the Trustee on your behalf, with the exception of the following: Death Benefit, Rehabilitation Benefit, and the Waiver of Premium Benefit will be paid according to the terms of the Policy. Should you become eligible to collect under the Transplant Surgery Benefit, Capital Sum, or Presumptive Disability Benefits, (if available) these benefits would be paid to the Trust, according to the provisions in the “Irrevocable Assignment of Right to Receive Benefits”.

21. I have received and I have CAREFULLY read the following documents:

    DI Retirement Security Program Disclosure Statement
    Declaration of Trust

    I further acknowledge that I have had ample opportunity to consult with My legal counsel regarding the above documents and that I have not relied on any representations or statements of Principal Life and/or Trustee, their legal counsel and/or their agents or representatives with respect to the above document. I have also CAREFULLY read this Declaration of Trust, and I understand its terms and conditions without reservation.

22. The Securities and Exchange Commission has adopted a rule which will enable corporations to learn the identity of their security holders whose securities are held by Banks and registered in "nominee" or "street" name. The Trustee's policy generally has been to specifically prohibit the disclosure of this information to such corporations in order to assure the confidentiality of each customer's security position to any company in which the customer has invested (as well as those companies in which customer may invest in the future) unless the customer specifically indicates to Trustee your authorization to disclose of such information. According to the rule, the issuing company would be permitted to use Grantor's name and related information for "corporate communication" purposes only.

☐ NO

Grantor does not want Grantor's name, address and securities positions disclosed to all the companies in which Grantor owns securities that are registered in "nominee" or "street" name.

☐ YES

Grantor wants Grantor's name, address, and securities positions disclosed to all the companies in which Grantor owns securities that are registered in "nominee" or "street" name.

23. Certification and Execution.

Under penalties of perjury, Grantor certifies that:

A. The number shown below is Grantor 's correct Tax Identification Number (or Grantor is writing for a number to be issued), and

B. Grantor is not subject to backup withholding either because Grantor has not been notified by the Internal Revenue Service (IRS) that Grantor is subject to backup withholding as a result of a failure to report all interest or dividends, or the IRS has notified Grantor that Grantor is no longer subject to backup withholding.

Date

Grantor

Social Security No. _____

Date of Birth _____

BANKERS TRUST COMPANY hereby accepts appointment as Trustee

BANKERS TRUST COMPANY

Date

Scott Johnson

Authorized Signature

DISCLOSURE STATEMENT
DI RETIREMENT SECURITY PROGRAM

PLEASE READ CAREFULLY

I. Introduction

This Disclosure Statement is intended for your general information only; it is not intended to provide you with actual legal advice or tax advice. ***You should consult with your attorney and your accountant for specific legal, tax and financial analysis and advice that is suited to your particular needs and goals.***

Principal Life Insurance Company is an Iowa Corporation with headquarters located at 711 High Street, Des Moines, Iowa, 50309 ("Principal Life"). Bankers Trust Company is an Iowa based Bank with headquarters located at 665 Locust Street, Des Moines, Iowa, 50309 ("Trustee"). Principal Life and Trustee are not affiliated with each other; they are separate entities working together and cooperatively to provide you with a special opportunity to help you protect your retirement contributions.

Disability income insurance is designed to help protect your current income in the event of a qualifying disability. It does not, traditionally, replace your ongoing pension contributions, or your employer's contributions on your behalf. As a result, a disability can devastate your ability to make retirement contributions Principal Life Insurance Company's DI Retirement Security Program involves the sale of an individual disability income insurance policy that is specifically designed to help supplement your retirement income if you become disabled.

In the event of a disability that qualifies you for benefits under the individual disability income insurance policy that you purchased, those benefits will be paid to a Trust. The benefits will be held and invested by the Trustee (according to the Grantor's instructions), and distribution of the trust assets will be made to you as the Trust beneficiary when you reach the age of 65 or 67, depending upon the Benefit Period you purchased in your Policy. You will then be able to use that distribution as a retirement income supplement. Trust assets will be distributed to your estate if you die prior to your 65th or 67th birthday.

It is important for you to be aware of the potential tax considerations implicated by your purchase of this policy and it is also important for you to be aware of the potential fees and expenses which will be charged to the Trust for administrative purposes.

II. Taxes

The taxation of the individual disability income insurance product you are about to purchase is controlled by the same rules that typically control the taxation of Individual Disability Income Insurance. In general, the following guidelines apply:

When the premiums are paid with after-tax dollars (dollars upon which tax has been paid), policy benefits paid by Principal Life to the Trust are not taxable to you as the Insured. Trust earnings are taxable annually to you, as the Trust Beneficiary.

When the premiums are paid with before-tax dollars (dollars upon which no tax has yet been paid), then policy benefits paid by Principal Life to the Trust are taxable annually to you as the Insured. If your employer has paid the premiums for the policy, the first six months of benefits paid to the Trust may be subject to FICA withholding. Trust earnings are taxable annually to you as the Trust Beneficiary, unless you instruct the Trustee to invest in a tax deferred or tax exempt type of investment.

In general, there is no tax on distribution to the Insured of funds upon which taxes have already been paid. In general, fees may be tax deductible, subject to certain limitations. In our opinion, the advantage of any deductibility will be minimal.

Because you are solely responsible for the tax liability of the Trust and must pay taxes, information must be supplied to you so you can fill out your tax return. The Trustee will prepare and provide to you a 1099-Substitute form declaring the taxable income and capital gains realized during the year. It will be your responsibility to include that taxable income with your personal tax return.

Upon written request, the Trust will reimburse you (Grantor) for income taxes due as a result of the inclusion of Trust income in the disabled Insured's income tax return. Reimbursements will be deducted from Trust income and, if necessary, principal.

The disclosure statements above are based on current tax law and they are subject to change. You should consult with your tax advisor in order to obtain specific tax advice.

III. Fees

Fees will not be assessed to the Trust until Principal Life begins making payments of disability benefits to the Trust. When disability benefits payments to the Trust commence, the Trust may be assessed certain specified fees as described herein in connection with Trust administration and investment management. Under some circumstances as described herein, the Trust may be assessed an Annuity Custodial Fee.

When fees are assessed, they will be paid first from the monthly benefits paid to the Trust, then secondly from Trust income and then finally from Trust principal.

The types of fees which may be assessed are as follows:

- Administration Fee – The administration fee is made in consideration of the administrative functions of the Trustee. The administration fee will be $50 per month.
- Investment Management Fee – Investment management fee(s) may be charged by investment management companies (such as a mutual fund company) as a separate fee. The amount of a particular investment management fee is established by the investment management company and is subject to change.
- Annuity Custodial Fee – The Annuity Custodial Fee may be assessed in certain specific circumstances if monthly disability benefits are only paid for a limited time period. If you are totally disabled for a limited time period, disability benefits payments to the Trust would cease when you are no longer totally disabled. In this situation, the Trustee in the exercise of its fiduciary duty may determine that the corpus of the Trust will not generate enough income to pay the applicable fees and also that the fees would reduce the amount of Trust principal. Upon making that determination, the Trustee shall give you the following options:

  a. to continue the Trust as is, allowing you to pay all or some of the fees or to contribute additional funds voluntarily to the Trust; or

  b. to instruct the Trustee to purchase a Single Premium Deferred Annuity (SPDA) with the Trust as the owner. The Trustee has a fiduciary responsibility to select an annuity, to perform due diligence on an ongoing basis, and to assure that legally required care of the annuity is provided. Prior to purchasing the SPDA, the Trustee will assess a one-time advance fee for the ongoing performance of its duties as follows:

Years remaining (or any part thereof) until The Grantor/Insured reaches age 59	Fee
0 – 5	$0
6 – 10	$100
11 – 15	$200
16 – 20	$300
21 – 25	$400
Over 25	$500

IV. Additional Information:

- The Individual Disability Income Policy that is used in conjunction with this “DI Retirement Security” program contains several “Other Benefits” that you might be eligible to collect. These “Other Benefits” will be paid to the Trustee on your behalf, with the exception of the following: Death Benefit, Rehabilitation Benefit, and the Waiver of Premium Benefit will be paid according to the terms of the Policy.

  Should you become eligible to collect under the Transplant Surgery Benefit, Capital Sum, or Presumptive Disability Benefits, these benefits would be paid to the Trust, according to the provisions in the “Irrevocable Assignment of Right to Receive Benefits”.

AUTHORIZATION FOR THE EXCHANGE
OF INFORMATION BETWEEN
PRINCIPAL LIFE INSURANCE COMPANY AND TRUSTEE

I hereby authorize and direct Principal Life Insurance Company ("Principal Life") to furnish the following specific information to Bankers Trust Company ("Trustee") in connection with the Principal Life Disability Income Insurance Policy which may be issued pursuant to my application of _____ (Date) (the "Policy"). Said information shall include but not be limited to: my name, date of birth, home and/or mailing address, social security number and/or tax identification number, Policy Number, the elimination period, the monthly benefit amount of the Policy, and the benefit period of the Policy.

I specifically ***do not authorize*** Principal Life to provide my medical, underwriting and/or financial information to Trustee beyond that which is specifically authorized in the preceding paragraph.

I hereby authorize and direct Trustee to furnish Principal Life with any Trust related information that is necessary in order for Principal Life to effectuate and administer the payment of disability benefits to the Trust pursuant to the terms of the Policy.

This authorization shall remain valid and in effect unless and until the policy terminates.

Signed at _____ _____ _____
(City-State) Date (Mo-Day-Yr) Grantor's Signature

Signed at _____ _____ _____
(City-State) Date (Mo-Day-Yr) Witness' Signature

IRREVOCABLE ASSIGNMENT OF
RIGHT TO RECEIVE BENEFITS

For value received, I, _____, do hereby irrevocably assign all my rights to receive any benefit, which may become due or payable under a Principal Life Insurance Company ("Principal Life") Policy that may be issued pursuant to my application dated _____, to an irrevocable trust account in care of Bankers Trust Company ("Trustee"), its successors and assigns, as Trustee, reserved, however, to myself all other rights under said policy.

The parties to this agreement hereto agree as follows:

1. This assignment is contingent upon the Principal Life issuance of the applied for individual disability income insurance policy under the DI Retirement Security Program.
2. This assignment is irrevocable, and the Grantor has no power to alter, amend, revoke, or terminate any provision or interest in or of this assignment, whether under this document or any other document, statute or other rule of law.

Dated at _____ this _____ day of _____, _____
(city, state) (month) (year)

_____ _____
Grantor Witness

Principal Life Insurance Company's
DI RETIREMENT SECURITY PROGRAM
CONTRIBUTION WORKSHEET
To Be Completed For Non-Owner Employees

This worksheet may be used for retirement plans which feature employee deferrals, and may be submitted with the application for individual disability income insurance for the use by the underwriter. Some individuals are paid on a weekly or bi-weekly basis (26 or 52 pay periods per year). In this case the contributions must be pro-rated to a monthly basis. This worksheet helps you to determine both the employee contribution and employer match amount on a monthly basis so that the correct monthly benefit can be applied for. Be sure that you begin with the employee's eligible income. Frequently bonuses and overtime pay are not eligible.

Note that you are encouraged to add an additional $50 per month on line (7), in order to cover the Trust administrative fees.

PLEASE PRINT LEGIBLY

		Monthly Amounts
1. Employee's total eligible annual income:	$_____ (1)	
2. Employee's retirement plan contribution:		
a. Annually:	_____ % or $ _____ (2a)	
b. Monthly (divide 2a dollar amount by 12):	(2b)	$_____
3. Employer's matching contribution:		
a. Annually:	_____ % or $ _____ (3a)	
b. Monthly (divide 3a dollar amount by 12):	(3b)	$_____
4. Sub-total: (add items 2b, 3b, and 4)	(4)	$_____
5. Existing Disability coverage in place with another company, that is specifically designed to protect your retirement contributions (Monthly Benefit Amount):	(5)	$_____
6. Sub-total: (subtract 5 from 4)	(6)	$_____
7. Monthly amount to cover trust administrative fee:	(7)	$ 50.00
8. Total monthly amount applied for: (add 6 and 7) ***(please round up to the nearest $25.00 increment)**	(8)	$_____ *

Applicant (Grantor) Name: (Print) _____ Date: _____

Agent/Broker/Licensed Rep: (Print) _____

As a result of this sale, your Principal Life representative (or his/her firm) may receive compensation (cash or otherwise) that is based in part on factors such as total deposits, assets or premium volume and persistency or profitability of the business he/she sells. The cost of this compensation may be directly or indirectly reflected in the premium or fee for this product. The representative may receive this compensation from the insurer and/or entities through which he/she places business.

Please contact your Principal Life representative if you have any questions about this compensation.

If you pay compensation directly to your Principal Life representative, he/she will provide you with a separate Disclosure of Compensation Information Form that provides additional information on the compensation he/she may receive.

Principal Life Insurance Company
Principal National Life Insurance Company
Members of Principal Financial Group®

P.O. Box 10431
Des Moines, IA 50306-0431

Authorization for Release of Personal Health Information – All States

(Applicable to Individual Life and Disability Insurance Customers)

Only one company is the issuer and responsible for obligations of any given policy and is hereinafter referred to as "the Company".

This authorization complies with the HIPAA Privacy Rule and permits health care providers and other covered entities to disclose personal health information.

Name of Proposed Insured/Patient (please print) _____ Date of Birth / /

I authorize any physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, health care provider, health plan, insurer, and/or any other entity subject to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) that has provided treatment, service, or coverage to me within the past 10 years to disclose my entire medical record to the Company, its agents, employees, insurance support organizations, reinsurers, and their representatives. This includes information concerning the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness (excluding psychotherapy notes as defined under HIPAA) and the use of alcohol, drugs, and tobacco. *Statements required by §164.508(c)(1)(ii), (c)(1)(iii).*

I understand my personal health information may be used or disclosed as set forth by this authorization. Protected health information includes information created or received by the Company. Protected health information also includes but is not limited to: hospital records, treatment records/office notes, alcohol or drug abuse treatment, consultation reports, workers' compensation information, diagnosis, prescriptions, test results, vocational testing/counseling information, benefit information, claims information, demographic information, and claims payment information. *Statement required by §164.508(c)(1)(i).*

By my signature, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct any physician, health care professional, hospital, clinic, medical facility, other health care provider or health plan, insurer, or other entity subject to HIPAA to release and disclose my medical record without restriction. I understand that my personal information, including my protected health information disclosed under this authorization, will be incorporated into and made a part of any life and/or disability insurance policy(s) issued by the Company in connection with the application(s) for insurance that I have submitted to the Company. I further understand that the policy(s) will be delivered to the policy owner, which may be my employer or other party. The information included and forming a part of such policy(s), including my protected health information, may be disclosed to the policy owner.

I understand that unless prohibited by state and/or federal law the protected health information is to be disclosed under this authorization so that the Company may: 1) underwrite my application for coverage, make eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage; and 5) conduct other legally permissible activities that relate to any coverage I have, have applied for, or may in the future apply for with the Company. *Statement required by §164.508(c)(1)(iv).*

The following groups of persons employed or working for the Company may use my personal health information which is described above: employees of the underwriting, administration, claim or legal departments and any other personnel of the Company, and its authorized representatives, and business associates that perform functions or services that pertain to any coverage I have, have applied for, or may in the future apply for with the Company. *Statement required by §164.508(c)(1)(ii).*

I understand any information disclosed under this authorization may no longer be covered by the privacy provisions of HIPAA and may be subject to redisclosure. *Statement required by §164.508(c)(2)(iii).*

This authorization shall remain in force for 24 months following the date of my signature below, and a copy of this authorization is as valid as the original. *Statement required by §164.508(c)(v).* I understand that I have the right to revoke this authorization at any time. The request for revocation must be in writing and sent to: Life and Disability Underwriting, Life and Health Segment, Principal Life Insurance Company and/or Principal National Life Insurance Company, Des Moines, IA 50392-1780. I understand that a revocation is not effective if the Company has relied on the protected health information disclosed to it or has a legal right to contest a claim under an insurance policy or to contest the policy itself. *Statement required by §164.508(c)(2)(i).* Such revocation shall not apply to any use or disclosure of my protected health information specifically allowed without authorization by HIPAA and no action relating to this authorization shall be construed as creating any restriction on the uses that HIPAA allows without my authorization.

I understand that if I refuse to sign this authorization to release my complete medical record, the Company may not be able to process my application for life and/or disability coverage, or if coverage has been issued, may not be able to make any such benefit payments. *Statement required by §164.508(c)(2)(ii).* Upon receipt of your signed authorization, a copy will be provided to you. *Statement required by §164.508(c)(4).* Any alteration of this form will not be accepted.

Signature of Proposed Insured/Patient or Personal Representative _____ **Date** / /

If you are the personal representative of the proposed insured/patient, describe the scope of your authority to act on this individual's behalf (parent, legal guardian, power of attorney, etc.) on the line above. *Statement required by §164.508(c)(1)(vi).*

Principal Life Insurance Company
Principal National Life Insurance Company
Members of Principal Financial Group®

P.O. Box 10431
Des Moines, IA 50306-0431

Authorization for Release of Personal Health Information – All States
(Applicable to Individual Life and Disability Insurance Customers)

Only one company is the issuer and responsible for obligations of any given policy and is hereinafter referred to as "the Company".

CLIENT COPY

This authorization complies with the HIPAA Privacy Rule and permits health care providers and other covered entities to disclose personal health information.

Name of Proposed Insured/Patient (please print) _____ Date of Birth / /

I authorize any physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, health care provider, health plan, insurer, and/or any other entity subject to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) that has provided treatment, service, or coverage to me within the past 10 years to disclose my entire medical record to the Company, its agents, employees, insurance support organizations, reinsurers, and their representatives. This includes information concerning the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness (excluding psychotherapy notes as defined under HIPAA) and the use of alcohol, drugs, and tobacco. *Statements required by §164.508(c)(1)(ii), (c)(1)(iii).*

I understand my personal health information may be used or disclosed as set forth by this authorization. Protected health information includes information created or received by the Company. Protected health information also includes but is not limited to: hospital records, treatment records/office notes, alcohol or drug abuse treatment, consultation reports, workers' compensation information, diagnosis, prescriptions, test results, vocational testing/counseling information, benefit information, claims information, demographic information, and claims payment information. *Statement required by §164.508(c)(1)(i).*

By my signature, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct any physician, health care professional, hospital, clinic, medical facility, other health care provider or health plan, insurer, or other entity subject to HIPAA to release and disclose my medical record without restriction. I understand that my personal information, including my protected health information disclosed under this authorization, will be incorporated into and made a part of any life and/or disability insurance policy(s) issued by the Company in connection with the application(s) for insurance that I have submitted to the Company. I further understand that the policy(s) will be delivered to the policy owner, which may be my employer or other party. The information included and forming a part of such policy(s), including my protected health information, may be disclosed to the policy owner.

I understand that unless prohibited by state and/or federal law the protected health information is to be disclosed under this authorization so that the Company may: 1) underwrite my application for coverage, make eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage; and 5) conduct other legally permissible activities that relate to any coverage I have, have applied for, or may in the future apply for with the Company. *Statement required by §164.508(c)(1)(iv).*

The following groups of persons employed or working for the Company may use my personal health information which is described above: employees of the underwriting, administration, claim or legal departments and any other personnel of the Company, and its authorized representatives, and business associates that perform functions or services that pertain to any coverage I have, have applied for, or may in the future apply for with the Company. *Statement required by §164.508(c)(1)(ii).*

I understand any information disclosed under this authorization may no longer be covered by the privacy provisions of HIPAA and may be subject to redisclosure. *Statement required by §164.508(c)(2)(iii).*

This authorization shall remain in force for 24 months following the date of my signature below, and a copy of this authorization is as valid as the original. *Statement required by §164.508(c)(v).* I understand that I have the right to revoke this authorization at any time. The request for revocation must be in writing and sent to: Life and Disability Underwriting, Life and Health Segment, Principal Life Insurance Company and/or Principal National Life Insurance Company, Des Moines, IA 50392-1780. I understand that a revocation is not effective if the Company has relied on the protected health information disclosed to it or has a legal right to contest a claim under an insurance policy or to contest the policy itself. *Statement required by §164.508(c)(2)(i).* Such revocation shall not apply to any use or disclosure of my protected health information specifically allowed without authorization by HIPAA and no action relating to this authorization shall be construed as creating any restriction on the uses that HIPAA allows without my authorization.

I understand that if I refuse to sign this authorization to release my complete medical record, the Company may not be able to process my application for life and/or disability coverage, or if coverage has been issued, may not be able to make any such benefit payments. *Statement required by §164.508(c)(2)(ii).* Upon receipt of your signed authorization, a copy will be provided to you. *Statement required by §164.508(c)(4).* Any alteration of this form will not be accepted.

Proposed Insured/Patient Copy – Sign Original / /

Signature of Proposed Insured/Patient or Personal Representative **Date**

If you are the personal representative of the proposed insured/patient, describe the scope of your authority to act on this individual's behalf (parent, legal guardian, power of attorney, etc.) on the line above. *Statement required by §164.508(c)(1)(vi).*

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Authorization for Withdrawals and/or Electronic Fund Transfers by the Principal Financial Group®

This Space for Agency and Home Office Use Only

Agency Number | Unit Number | Representative | Date MM/DD/YYYY

Attn | From

Instructions

1. Complete the section below – please print or type.
2. Sign and date this authorization form.
3. Be sure to attach an unsigned, Void Check so we may duplicate the magnetic coding.
4. Any initial insurance or annuity premium check should be payable to Principal National Life Insurance Company or Principal Life Insurance Company.

Terms and Conditions

1. Withdrawals or electronic fund transfers for existing insurance policy or annuity contract premiums will be made without regard to any insurance policy or annuity contract applications that may be pending with this company. When any insurance policies or annuity contracts are issued, the amount of the withdrawals or electronic fund transfers will be increased sufficiently to include the premium or the new policy contract.
2. Withdrawals or electronic fund transfers will be made on or around the day of the month that the earliest payment (any one mutual fund, policy or contract) is due, unless another date is requested below.
3. While premiums are paid under this plan, premium notices will not be mailed nor will the Automatic Premium Loan privilege be available. Any cancelled instruments will constitute receipts for payment of premiums. Transaction confirmations will be prepared and sent as required by law and regulation.

Type of Request (Please check where applicable)

☐ First Request ☐ Change of Institutions or Accounts ☐ Add to Present Plan No. _____

☐ Flex Draw Date to (Not available on certain Life products) _____

(Types of Account) ☐ Checking ☐ Savings

Authorization for Withdrawals and/or Electronic Fund Transfers

This authorization applies to the attached application (if any) dated Date MM/DD/YYYY and/or the following:

Account/Policy Contract Number

Monthly Amount (if applicable)

$ | $ | $ | $ | $

I authorize Principal National Life Insurance Company and/or Principal Life Insurance Company (hereafter referred to as "Companies") to debit my account as needed to pay premiums.

Name of Financial Institution | Phone ( )

Address | City | State | ZIP

Account Holder's Name | Transit and Routing No. | Account No.

Joint Account Holder's Name

I authorize the financial institution named above to honor withdrawals and/or electronic fund transfers by the Companies listed above. I understand if any withdrawals or electronic fund transfers are dishonored by you, whether with or without cause, that you shall be under no liability.

This authorization will remain in effect until cancelled either by myself, the Companies, or the financial institution named above. Notification of such cancellation must be given within 10 working days of the transaction by the party canceling the authorization.

X _____ _____ _____ _____

Signature of Account Holder | City | State | Date MM/DD/YYYY

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Notice and Consent

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Agency Number	Unit Number	Agent	Date MM/DD/YYYY

Attn	From

NOTICE AND CONSENT FOR BLOOD OR OTHER BODILY FLUID TESTING WHICH MAY INCLUDE AIDS VIRUS (HIV) ANTIBODY/ANTIGEN TESTING

Unless precluded by law, tests may be performed to determine the presence of antibodies or antigens to the Human Immunodeficiency Virus (HIV), also known as the AIDS virus. The HIV antibody test that we perform is actually a series of tests done by a medically accepted procedure. The HIV antigen test directly identifies AIDS viral particles. These tests are extremely reliable. Other tests which may be performed include determinations of blood cholesterol and related lipids (fats) and screening for liver or kidney disorders, diabetes, and immune disorders.

All test results will be treated confidentially. They will be reported by the laboratory to the Insurer. When necessary for business reasons in connection with insurance you have or have applied for with the Insurer, the Insurer may disclose test results to others such as its affiliates, reinsurers, employees, or contractors. If the Insurer is a member of the Medical Information Bureau (MIB, Inc.) and if the test results for HIV antibodies/antigens are other than normal, the Insurer will report to the MIB, Inc. a generic code which signifies only a non-specific test abnormality. If your HIV test is normal, no report will be made about it to the MIB, Inc. Other test results may be reported to the MIB, Inc. in a more specific manner. The organizations described in this paragraph may maintain the test results in a file or data bank. There will be no other disclosure of test results or even that the tests have been done except as may be required or permitted by law or as authorized by you.

If your HIV test results are normal, no routine notification will be sent to you. If the HIV test results are other than normal, the Insurer will contact you. The Insurer may also contact you if there are other abnormal test results which, in the Insurer's opinion, are significant. The Insurer may ask you for the name of a physician or other health care provider to whom you may authorize disclosure and with whom you may wish to discuss the results.

Positive HIV antibody/antigen test results do not mean that you have AIDS, but that you are at significantly increased risk of developing AIDS or AIDS-related conditions. Federal authorities say that persons who are HIV antibody/antigen positive should be considered infected with the AIDS virus and capable of infecting others.

Positive HIV antibody or antigen test results or other significant blood abnormalities will adversely affect your application for insurance. This means that your application may be declined, that an increased premium may be charged, or that other policy changes may be necessary.

I have read and I understand this Notice and Consent For Blood or Other Bodily Fluid Testing Which May Include HIV Antibody/Antigen Testing. I voluntarily consent to the collection of blood or other bodily fluid from me, the testing of that blood or other bodily fluid, and the disclosure of the test results as described above.

I understand that I have the right to request and receive a copy of this authorization. A photocopy of this form will be as valid as the original.

I authorize the Company to send the result to the following physician or health care provider:

Physician's Name

Address	City	State	ZIP

X _____ _____

Signature of Proposed Insured — Date MM/DD/YYYY

_____ / / _____

Print Name — Date of Birth MM/DD/YYYY

X _____

Signature of Agent/Broker

Sign two copies. Send one signed copy to the Home Office. One copy is for the Insured.

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Physician's Name

Address	City	State	ZIP

X _____ _____

Signature of Proposed Insured — Date MM/DD/YYYY

_____ / / _____

Print Name — Date of Birth MM/DD/YYYY

X _____

Signature of Agent/Broker

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Principal Life Insurance Company
P.O. Box 14455
Des Moines, IA 50306-3455

Disability Insurance
Notice of Insurance Information Practices

We appreciate you applying for insurance with our company.

This notice explains our information practices. It describes the information we need, possible sources, reasons for collection and how your data is kept confidential. This notice also tells how we process your application. Please keep this notice for your records. The word "you" in this notice means the proposed insured.

Overview

Your insurance application contains specific personal questions about you. We need your answers to decide if you qualify for coverage. If you qualify, we determine the coverage for which you are eligible and the cost. This process, known as underwriting, takes into account factors such as physical and mental conditions, medical history, income, occupation, age, and hobbies. Underwriting makes it possible to keep rates fair.

Sources and Types of Information

You are the primary source of personal data. We may call you to verify data on your application, or to obtain more data. We may ask you about your age, medical history, occupation, income, habits, hobbies and other personal characteristics. We may contact other sources for personal data, including: (1) spouse, (2) accountant, (3) lawyer, (4) employer, (5) other persons who know you well, (6) insurance companies to which you may have applied for insurance in the past, (7) MIB, Inc., (8) governmental agencies, and (9) consumer reporting agencies. We may also contact your doctor, hospital or other health care provider to clarify your medical history. We may ask that you have medical exams and tests.

Proper underwriting of your application may require use of an investigative consumer report obtained from a consumer credit reporting agency. The agency would collect information from the same sources listed above and would prepare a written report on the same topics described in the previous paragraph, including your credit, driving, court, and medical histories. Upon written request, we will tell you if a report is made. We will provide the name and address of any outside agency who prepares the report. We will also tell you the nature and substance of the report. It would contain the same types of information that we collect from the other sources listed above. This data may be obtained through interviews with you, your family, friends, neighbors and associates.

You may ask that you be interviewed if we request this report. Data collected and retained by a consumer reporting agency may be disclosed to other insurance companies having proper authorization.

Our Use of Information

We follow strict standards to safeguard your personal information. It will be seen only by employees and agents of Principal Life Insurance Company who underwrite and administer your coverage. We may also provide data to: (1) MIB, Inc.; (2) other insurance companies, if you authorize release of the data to them; (3) our reinsurers, if needed to secure reinsurance; (4) federal and state agencies and others if required by law; (5) our research personnel (anonymously) to help market our products.

Access To Your Data

Upon your written request, we will provide you with the nature and scope of your personal data in our records. You must give us proper identification. We will respond to your request within 21 days from the date of receipt. You may be charged a fee for any copies of your data. Medical data will be disclosed to a doctor of your choice, unless you instruct us to send the medical data directly to you. (Medical information received from doctors and other health care providers may be prohibited from redisclosure.) You have the right to see your nonmedical data and obtain a copy. You have the right to correct or amend any data in your file. Any request for correction or amendment must be in writing. If we agree with you, we will notify anyone we may have given such incorrect data. We will also delete data from your file if we agree it is incorrect. If we disagree with your correction or amendment, we will give you our reason. You may respond in writing listing the basis on which you dispute the correctness of the data. Your response will be added to your file.

Information obtained through consumer reporting agencies will be furnished to you according to the provisions of the Fair Credit Reporting Act. You have a right to see and obtain a copy of any report made. If you are requesting a copy of an investigative consumer report prepared by a consumer reporting agency, we will provide that report within 5 days of receipt of your request.

Upon written request, we will tell you the name of any person to whom we may have given your data. You should direct all requests to: Disability Insurance Underwriting Officer, P.O. Box 14455, Principal Life Insurance Company, Des Moines, Iowa 50306-3455 (Telephone 1-800-247-9988, extension 83797).

MIB Pre-Notice

Information regarding your insurability will be treated as confidential. Principal Life Insurance Company or its reinsurers may, however, make a brief report thereon to the MIB, Inc., formerly known as Medical Information Bureau, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its Members. If you apply to another MIB Member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill, Suite 400, Braintree, MA 02184-8734.

Principal Life Insurance Company, or its reinsurers, may also release information in its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.

DISCLOSURE – Give to Proposed Insured

