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

Individual 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).

☐ If utilizing the TeleApp process, please 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.

If using the traditional application process, obtain and complete **PART B** of the application. Answer all questions legibly in blue or black ink. The **applicant** is required to initial any changes. A personal telephone interview (PTI) is also required when using the traditional application process. To schedule the PTI call 1-888-835-3277.

NOTE: The TeleApp Counselor will offer to order Routine Underwriting Requirements for all new applications.

☐ **Association Sales Program applications** require home office pre-approval and a copy of the Association Endorsement letter. If you have an Association, whose members you market disability insurance products to, please contact Jeff Hannemann at 1-800-247-9988, x20992 or Hannemann.Jeff@principal.com for pre-approval.

☐ 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 **verification of income/financial** documentation (if applicable). For Business Loan Protection Rider (BLPR), submit a copy of the loan documentation, if BLPR is approved in the written state.

☐ 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.

☐ 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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Principal Life Insurance Company
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Individual Disability Insurance 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. Underwriting Requirements (Please check the underwriting requirements that have been ordered)

☐ TeleApp/Personal Telephone Interview (PTI) Confirmation Number ______________

If TeleApp or PTI has not been scheduled, please call 1-888-TeleApp and schedule at this time.

Is an interpreter required for TeleApp? ☐ Yes ☐ No If Yes, list language: ______________

☐ HOBP/HOS Ordered through ______________

☐ Urine-HIV Ordered through ______________

☐ Mini/Paramed Ordered through ______________

☐ EKG Ordered through ______________

☐ APS ______________ ☐ Other ______________

5. 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 policyowner) ______________

____

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P.O. Box 14455
Des Moines, IA 50306-3455

Individual Disability Insurance Producer Report

Proposed Insured ______________________________ Policy Number ______________

5. Additional Information (Continued)

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

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

f. If special dating is essential, indicate policy date desired: ___/___/___ . If money is taken with application, requests for advance dating will not be 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? $ ______________

h.

Product	Payment Mode	Mode Premium	Total Annual Premium

i. Comments or special instructions ______________________________

6. 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				/ /

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Principal Life Insurance Company
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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

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)

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
Social Insurance Substitute (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
☐ Regular Occupation
☐ Residual Disability and Recovery Benefit Rider
☐ Short Term Residual Disability Benefit: ☐ 6 month ☐ 12 month
☐ Transitional Occupation Period: ☐ 2 year ☐ 5 year ☐ to age 65 ☐ to age 67 ☐ to age 70
☐ 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
*You must apply for 75% of eligible expenses to qualify for Benefit Update

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Disability Insurance Application – PART A

Proposed Insured ______________________________ Policy Number (if known) ______________

3. Disability Income (Continued)

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.

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Principal Life Insurance Company
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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: ______________________________

	Current Year	Last Yr.	2 Yrs Ago
Tax Year:	________	________	________
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 been treated for, or been diagnosed as having a heart condition, chest pain, stroke, back or neck problem, sleep disorder, 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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Principal Life
Insurance Company
P.O. Box 14455
Des Moines, IA 50306-3455

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 material misrepresentations could mean denial of an otherwise valid claim and rescission of the policy during the contestable period.

When Coverage Becomes Effective: I understand and agree that the Company shall incur no liability until: (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 delivery 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 Application or the Delivery Receipt form, and any required Amendment and Acceptance or other forms are 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. If the application was submitted COD (cash on delivery) or a request for a change in the Policy date is received, the Policy Date may be changed to the date coverage becomes effective and a new Data Page will be sent to the Owner.

Limitation of Authority: I understand and agree that no licensed agent, broker, 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. Subject to the Time Limit on Certain Defenses provision in the policy, no knowledge of any fact on the part of any licensed agent, broker, 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 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)

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

Disability Insurance Application – PART C

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, licensed insurance agent, broker, 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 notice required by any Fair Credit Reporting Act. It 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.

Pre-Existing Condition Limitation: The policy being applied for does not cover Disability or loss which begins within two years after the effective date of coverage(s) and results from a pre-existing condition which occurred within the two year period prior to the effective date of coverage(s) and was not disclosed or was misrepresented in this application.

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, City, State and Date are required.**)

Proposed Insured *(Signature)* 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 / /
Licensed Agent/Broker/Representative X	License Number		Date / /
Co-signature by Resident Licensed Rep. (If applicable in your state) X	License Number		Date / /

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Insurance Company
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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 material misrepresentations could mean denial of an otherwise valid claim and rescission of the policy during the contestable period.

When Coverage Becomes Effective: I understand and agree that the Company shall incur no liability until: (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 delivery 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 Application or the Delivery Receipt form, and any required Amendment and Acceptance or other forms are 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. If the application was submitted COD (cash on delivery) or a request for a change in the Policy date is received, the Policy Date may be changed to the date coverage becomes effective and a new Data Page will be sent to the Owner.

Limitation of Authority: I understand and agree that no licensed agent, broker, 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. Subject to the Time Limit on Certain Defenses provision in the policy, no knowledge of any fact on the part of any licensed agent, broker, 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 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, licensed insurance agent, broker, 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 notice required by any Fair Credit Reporting Act. It 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.

Pre-Existing Condition Limitation: The policy being applied for does not cover Disability or loss which begins within two years after the effective date of coverage(s) and results from a pre-existing condition which occurred within the two year period prior to the effective date of coverage(s) and was not disclosed or was misrepresented in this application.

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.

AGREEMENT/AUTHORIZATION – Give to Proposed Insured

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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) $ ______________

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 does not create any temporary or interim insurance. However, it does set the date when the insurance under the policy applied for will become effective if all required conditions are met. No licensed agent, broker, 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 the terms of the policy 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 the terms of the policy 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 the terms of the policy 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 before any insurance becomes effective. Otherwise there is NO insurance under the terms of the policy 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 to the best of your knowledge and belief.
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--

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

All the following conditions must be fulfilled exactly before any insurance becomes effective. Otherwise there is NO insurance under the terms of the policy 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 to the best of your knowledge and belief.
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). Subject to the Time Limit on Certain Defenses provision in the policy, no knowledge of any fact on the part of any licensed agent, broker, 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 –** 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); $500,000 (Disability Buy-Out Maximum Aggregate Benefit).

   The coverage available under the terms of the policy, 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, 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 than 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 LICENSED AGENT/BROKER/REP. OR LEAVE THE PAYEE BLANK.

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Principal® Financial Group

Mailing Address:
Des Moines, IA 50392-0001

Principal Life Insurance Company

Insurance Application

Proposed Insured ____________________

Date of Birth ____ / ____ / ______ Policy Number (If known) ____________________

PART B

All references to "you" mean the Proposed Insured.

ACTIVITIES/HEALTH HABITS

1. In the last five years have you, or do you have plans to:
   a. be a member of any armed forces or military unit? ☐ Yes ☐ No
   b. pilot any type of aircraft? ☐ Yes ☐ No
   c. engage in scuba/skin diving, motor vehicle racing, skydiving or any other hazardous sporting activity? ☐ Yes ☐ No
   d. live outside the United States or Canada? (If yes, explain below) ☐ Yes ☐ No
   e. travel outside the United States or Canada? (If yes, explain below) ☐ Yes ☐ No
2. In the last five years have you:
   a. been in a motor vehicle accident, been convicted of driving while intoxicated or had more than one moving violation? (If yes, explain below) ☐ Yes ☐ No
   b. been on parole or probation or convicted of a felony or misdemeanor? (If yes, explain below) ☐ Yes ☐ No
3. In the last ten years have you used any tobacco or nicotine products? ☐ Yes ☐ No
   (Indicate date last used and amount per day)
   a. ☐ cigarettes ____________ d. ☐ pipe ____________
   b. ☐ cigars ____________ e. ☐ chewing tobacco/snuff ____________
   c. ☐ nicotine patch/gum ____________ f. ☐ other ____________
4. In the last ten years have you consumed alcoholic beverages? ☐ Yes ☐ No
   If yes, date last used? ____________ Number of drinks per week: ____________
5. In the last ten years have you used cocaine, marijuana, methamphetamines, barbiturates or other controlled substances? ☐ Yes ☐ No
6. Have you ever been advised to limit or discontinue the use of alcohol or drugs; or sought or received treatment because of your alcohol or drug use? ☐ Yes ☐ No

DETAILS TO QUESTIONS 1-6

Quest. #	Include dates and details as requested above.

Mailing Address:
Des Moines, IA 50392-0001

Principal Life Insurance Company

Insurance Application

Proposed Insured ______________________________

Date of Birth ____ / ____ / ______ Policy Number (If known) ______________________________

PART B – (Continued)

INCOME/OCCUPATION

For Life, complete questions 7 and 8. For DI, complete questions 7-17. In all cases, Part B continues on the next page.

7. Primary occupation ______________________________ Employer ______________________________
8. Annual income from occupation $ ______________________ Other Income $ ______________________
   Source of other income ______________________ Net Worth (Assets – Liabilities) $ ____________
9. Current Employment Information
   a. Type of business or industry ______________________________
   b. Job title ______________________________
   c. What are your job activities and percentage of time spent in each? ______________________________
   ____
   ____
   d. How many hours do you usually work per week in your primary job? ______________________________
   e. Total number of employees: Full-time __________ Part-time __________ Sub-contracted __________
   f. How many employees do you supervise? ________________
10. How long have you been employed by your current employer? _____________ (If less than three years, provide details below, e.g., employers, occupations and dates for last five years.)
11. Do you work out of your home? (If yes, how many hours per week? ____________) ☐ Yes ☐ No
12. Do you have any other part-time or full-time jobs? (If yes, explain below) .... ☐ Yes ☐ No
13. Are you actively at work on a full-time basis without medical restriction? (If no, explain below) .... ☐ Yes ☐ No
14. Do you intend to change jobs or employment in the next 6 months? (If yes, explain below) .... ☐ Yes ☐ No
15. Have you ever requested or received any type of disability benefits (including worker's compensation and state disability) for an injury or illness? (If yes, explain below)............ ☐ Yes ☐ No
16. Do you have an ownership interest in any business you work for? .... ☐ Yes ☐ No
    If yes, ownership percentage _____ length of ownership ______________________________
    Type of business: ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Sole Proprietorship ☐ Limited Liability Company ☐ Other ______________
17. Have you, or any business owned in whole or part by you, ever been in bankruptcy or any similar proceedings? (If yes, provide date discharged, type and chapter).................. ☐ Yes ☐ No

DETAILS TO QUESTIONS 7-17

Quest. #	Include dates and details as requested above.

Principal® Financial Group

Mailing Address:
Des Moines, IA 50392-0001

Principal Life Insurance Company

Insurance Application

Proposed Insured ____________________

Date of Birth ____ / ____ / ______ Policy Number (If known) ____________________

PART B – (Continued)

MEDICAL HISTORY (Provide details to yes answers, questions 18-20 below)

18. In the last ten years, have you had, been treated for or been diagnosed as having:
    a. high blood pressure, heart attack, chest pain, heart murmur, irregular heart beat, stroke, or any other disease or disorder of the heart or blood vessels?........................ ☐ Yes ☐ No
    b. cancer or a tumor, cyst or growth? .... ☐ Yes ☐ No
    c. asthma, bronchitis, emphysema, tuberculosis or any other disease or disorder of the lungs or respiratory system?.. ☐ Yes ☐ No
    d. seizure, paralysis, headaches, multiple sclerosis or any other disease or disorder of the brain or nervous system?.. ☐ Yes ☐ No
    e. chronic fatigue, stress, depression, anxiety or any other emotional or psychological disorder? .... ☐ Yes ☐ No
    f. hepatitis, colitis, ulcer, cirrhosis, irritable bowel or any other disease or disorder of the liver, gallbladder, pancreas or digestive tract? .... ☐ Yes ☐ No
    g. diabetes, borderline diabetes, sugar in the urine, thyroid disorder or any other disease or disorder of the glandular system? .... ☐ Yes ☐ No
    h. kidney stones, nephritis, any blood or protein in the urine, sexually transmitted disease, prostate disorder, breast disorder or any other disease or disorder of the urinary or reproductive system?... ☐ Yes ☐ No
    i. back or neck pain, disc problems, spinal sprain or strain, sciatica, arthritis, carpal tunnel syndrome, or any other disease or disorder of the bones, joints, or muscles? ... ☐ Yes ☐ No
    j. any disease or disorder of the eyes, ears, nose, throat or skin? .... ☐ Yes ☐ No
19. (DI Only) Are you currently pregnant or have you had complications of pregnancy in the last ten years? .... ☐ Yes ☐ No
20. In the last ten years have you been treated for or been diagnosed as having ARC (AIDS Related Complex, which may include symptoms of swollen glands, unintentional weight loss, chronic diarrhea, fever, night sweats or fatigue) or Acquired Immunodeficiency Syndrome (AIDS) or any other disease or disorder of the immune system?...................... ☐ Yes ☐ No

DETAILS TO QUESTIONS 18-20

Quest. #	For yes answers, include dates, details, diagnosis, types and results of treatment, healthcare provider's full name and address.

Principal Financial Group

Mailing Address:
Des Moines, IA 50392-0001

Principal Life Insurance Company

Insurance Application

Proposed Insured ______________________________

Date of Birth ____ / ____ / ______ Policy Number (If known) ______________________________

PART B – (Continued)

MEDICAL HISTORY (Provide details to yes answers, questions 21-26 below)

21. Who is your Primary Physician? ☐ None
    a. Name   Phone Number

    Street   City   State   Zip

    b. Date last seen, reason and details

22. In the last ten years:
    a. have you had any medical tests (other than an HIV test), hospitalization, illness or injury not provided in response to a previous question? (If yes, explain below) .... ☐ Yes ☐ No
    b. have you consulted a doctor, chiropractor, psychiatrist, psychologist, counselor, therapist or other healthcare provider not provided in response to a previous question? (If yes, explain below) .... ☐ Yes ☐ No

23. Are you taking or have you been advised to take any medication or treatment not provided in response to a previous question? (If yes, explain below) .... ☐ Yes ☐ No

24. Current Ht. ________ Wt. ______ Have you lost more than 10 lbs. in the last year? ..... ☐ Yes ☐ No
    If yes, ______ lbs./kgs. Indicate reason ______________________________

25. a. Has either of your natural parents lived to at least age 60? .... ☐ Yes ☐ No
    b. Do any of your natural parents or siblings have a history of diabetes, cancer, stroke or heart disease? .... ☐ Yes ☐ No
    If yes, provide details (i.e., relationship, type of disease, age diagnosed, current age or age at death):

26. Have you ever had any life, health or disability insurance rated, ridered or declined? (If yes, explain below)... ☐ Yes ☐ No

DETAILS TO QUESTIONS 21-26

Quest. #	Include dates and details as requested above.

Mailing Address:
Des Moines, IA 50392-0001

Principal Life Insurance Company

Disability Buy-Out Application Supplement

1. Proposed Insured ______________________ Date of Birth ______________

2. Name of your business ______________________ Date organized/purchased ______________

Benefits:

☐ Lump Sum – Benefit Amount $ __________

☐ Monthly Payments – Monthly Amount $ __________

Elimination Period: ☐ 365 day ☐ 540 day ☐ 730 day

Benefit Period Factor: ☐ 24 ☐ 36 ☐ 60

☐ Combination Method (Complete Lump Sum and Monthly Payment Items above)

Optional Benefit Riders:

☐ Benefit Update

☐ Other ______________________

Owner (**Must** be other than the proposed insured) – (Please list owner and have sign this form and Part C).

Name (Owner) ______________ Address ______________

City ______________ State ______ Zip ______________ Owner Taxpayer ID Number ______________

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

4. Your percent of ownership ________%

5. Number of employees: ________full time ________part time ________subcontracted

6. Average number of hours worked per week for the firm _______

7. Has your firm or any of its principals declared bankruptcy in the last 5 years?……………..… ☐ Yes ☐ No
If Yes, explain: ______________________

8. Are all full-time active owners applying for Disability Buy-Out insurance?…………………….. ☐ Yes ☐ No
If No, explain: ______________________

9. Are any owners related? (i.e. parent, child, spouse or sibling)………………………………….. ☐ Yes ☐ No
If Yes, indicate relationship: ______________________

10. List all owners proposed for Disability Buy-Out insurance:

Name	Age	Job Title	% of Ownership

11. Type of Buy-Sell Agreement in force or planned: ☐ Cross purchase ☐ Entity purchase ☐ Stock redemption
☐ Other (describe) ______________________

Mailing Address:
Des Moines, IA 50392-0001

Principal Life Insurance Company

Disability Buy-Out Application Supplement

Proposed Insured ____________________ Policy Number (if known) __________

12. a. Valuation Basis:
    - ☐ Principal Life's underwriting guidelines
    - ☐ Other (i.e. book value, sale of similar business, etc.) ____________________

    b. **TOTAL CURRENT VALUE** based on the method indicated in question 12.a. $ __________

	Year to Date	Last Tax Year	Prior Tax Year
13. **TOTAL OWNERS' SALARIES**	$		
14. **GROSS ANNUAL RECEIPTS**	$		
15. **NET ANNUAL PROFIT**	$		
16. **BOOK VALUE**	$		

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 ____________________ ____________________ ______ ___/___/______
Proposed Insured *(Signature)* Signed at: City State Date

X ____________________ ___/___/______
Witness (Licensed Agent/Broker/Representative) Date

Mailing Address:
Des Moines, IA 50392-0001

Principal Life Insurance Company

Disclosure of Compensation Information

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

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

Authorization for Release of Personal Health Information – All States

(Applicable to Individual Life and Disability Insurance Customers)

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).*

Insurance products from the Principal Financial Group®(The Principal®) are issued by Principal National Life Insurance Company (except in New York) and Principal Life Insurance Company.

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Principal Life Insurance Company
Principal National Life Insurance Company
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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).*

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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).*

Insurance products from the Principal Financial Group®(The Principal®) are issued by Principal National Life Insurance Company (except in New York) and Principal Life Insurance Company.

This completed document is for restricted use only. No part may be copied nor disclosed without prior consent of The Principal®.

Principal Financial Group

Principal Life Insurance Company
Principal National Life Insurance Company
Members of Principal Financial Group®
P.O. Box 10431, Des Moines, IA 50306-0431

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

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

Insurance products from the Principal Financial Group®(The Principal®) are issued by Principal National Life Insurance Company (except in New York) and Principal Life Insurance Company.
This completed document is for restricted use only. No part may be copied nor disclosed without prior consent of The Principal®.

Principal® Financial Group

Mailing Address:
Des Moines, IA 50392-0001

Principal Life Insurance Company

Notice and Consent

Information Form For Insurance Proposed Insured

Before consenting to testing, please read the following information:

To evaluate your insurability, the insurer named above (the Insurer) has requested that you provide a sample of your blood and/or oral fluids for testing and analysis. 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. One of the tests to be performed on this sample will be a test to determine the presence of human immunodeficiency virus (HIV) antibodies. By signing and dating this form you agree that this test may be done and that underwriting decisions will be based on the test result. The HIV Antibody Test consists of a series of three tests as outlined below which will be performed on your sample by a licensed laboratory through a medically accepted procedure.

AIDS:

Acquired Immunodeficiency Syndrome (AIDS) is a life-threatening disorder of the immune system, caused by a virus, HIV. The virus is transmitted by sexual contact with an infected person, from an infected mother to her newborn infant or by exposure to infected blood (as in needle sharing during IV drug use). Persons at high risk of contracting AIDS include males who have had sexual contact with another man, intravenous drug users, hemophiliacs, and sexual contacts with any of these persons. AIDS does not typically develop until a person has been infected with HIV for several years. A person may remain free of symptoms for years after becoming infected. If symptoms do develop, they may include fever (including night sweats), weight loss, swollen glands, fatigue, diarrhea or white spots in the mouth.

The HIV Antibody Test:

Purpose: This test is being run to determine whether you may have been infected with HIV. If you are infected, you are probably not insurable. This test is not a test for AIDS, AIDS can only be diagnosed by medical evaluation.

When an HIV Antibody test is performed, it will be performed only by a licensed laboratory and according to the following medical protocol:

1) An initial ELISA test will be done. If such test is negative, a negative finding will be reported by the laboratory to the Insurer.
2) If the initial ELISA test is positive, another ELISA test will be performed.
   a) If the second ELISA test is also positive, a Western Blot test will be performed to confirm the positive results of the two ELISA tests.
   b) If the second ELISA test is negative, a third ELISA test will be performed. If the third ELISA test is positive, a Western Blot test will be performed to confirm the previous positive results. If the third ELISA test is negative, a negative result will be reported to the Insurer.
3) Only if at least two ELISA tests and a Western Blot test are all positive will the result be reported as positive. All other results will be reported as negative by the laboratory to the Insurer.

This test is not a test for AIDS. It is a test for antibodies to the HIV virus, the causative agent for AIDS, and shows whether you have been exposed to the virus. A positive test result does not mean that you have AIDS but shows that the risk that you will develop problems with your immune system is significantly increased. If your test result is positive, you may wish to consider further independent testing at your own cost.

Confidentiality of Test Results:

All test results are required to be treated confidentially. They will be reported by the laboratory to the Insurer. The test results may be disclosed as required by law or may be disclosed to employees of the Insurer who have the responsibility to make underwriting decisions on behalf of the Insurer or to its outside legal counsel who need such information to effectively represent the Insurer in regard to your application. The results may be disclosed to a reinsurer, if the reinsurer is involved in the underwriting process. The test may be released to an insurance medical information exchange under procedures that are designed to assure confidentiality, including the use of general codes that also cover results of tests for other diseases or conditions not related to AIDS, or for the preparation of statistical reports that do not disclose the identity of any particular person.

Notification of Test Results:

If your test results are negative, no routine notification will be sent to you. If your test results are reported by the laboratory to the Insurer as being positive, you are entitled to that information if you so desire. Because a trained person should deliver that information to you so that you can understand clearly what the test result means, you are asked to list your private physician or other designee so that the Insurer can have him or her tell you the test result and explain its meaning.

Further Information:

For further information about AIDS, the meaning of HIV-related test results and the availability and location for HIV related counseling services, please call the Department of Health's state-wide toll-free number: 1-800-541-AIDS.

Consent:

I have read this Notice and Consent and I voluntarily consent to the withdrawal of blood from me, the testing of that blood, and the disclosure of the test results as described above.

Name of physician for reporting a possible positive result

Address | City | State | ZIP

There is also a form inside the blood profile kit which must be read and signed. If you choose not to sign below on this form or the form in the kit, we will be unable to consider your request for coverage. If you wish for us to continue processing, sign below.

X ____________________ X ____________________

Signature of Proposed Insured or Parent/Guardian | Date MM/DD/YYYY

Print Name

Address | City | State | ZIP

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

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X ______________________ X ______________________

Signature of Proposed Insured or Parent/Guardian — Date MM/DD/YYYY

Print Name

Address City State ZIP

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

Principal Life Insurance Company
P.O. Box 10431
Des Moines, IA 50306-0431

Compensation Information

____
(Producer Name)

is an insurance producer (producer) licensed by the State of New York. Producers are authorized by their license to confer with insurance purchasers (purchasers) about the benefits, terms and conditions of insurance contracts; to offer advice concerning the substantive benefits of particular insurance contracts; to sell insurance; and to obtain insurance for purchasers. The role of the producer in any particular transaction typically involves one or more of these activities.

Compensation will be paid to the producer, based on the insurance contract the producer sells. Depending on the insurer(s) selling the insurance contract, or by another third party, such compensation may vary depending on a number of factors, including the insurance contract(s) and the insurer(s) the purchasers select. In some cases, other factors such as the volume of business a producer provides to an insurer, or the profitability of insurance contracts a producer provides to an insurer, may also affect compensation.

The purchasers may obtain information about compensation expected to be received by the producer, based in whole or in part on the sale of insurance to the purchasers, and (if applicable), compensation expected to be received based in whole or in part on any alternative quotes presented to the purchasers, by requesting such information from the producer.

TO BE LEFT WITH INSURANCE PURCHASERS

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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. 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. You have the right to receive in writing the specific information leading to an adverse underwriting decision. We reserve the right to disclose medical information only to a doctor, and we will request that you provide us with the name and address of your physician. 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.

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

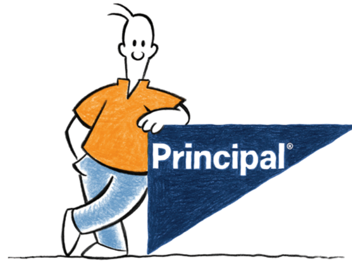
Information regarding your insurability will be treated as confidential. Principal Life Insurance Company or its reinsurers may, however, make a brief report thereon to the MIB, Inc., formerly known as Medical Information Bureau, a not-for-profit membership organization of insurance companies, which 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 Park, 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

This completed document is for restricted use only. No part may be copied nor disclosed without prior consent of The Principal®.



Individual Disability Insurance

TeleApp Interview

Thank you for your interest in Individual Disability insurance from Principal Life Insurance Company. As part of the application process, your financial representative has a TeleApp interview scheduled for you. The TeleApp process involves a confidential telephone interview to ask you insurability questions which can help speed up the application process.

Your financial representative works closely with a Principal Life TeleApp counselor. These counselors are professional, highly-trained interviewers who have undergone extensive training to assist you through the TeleApp process. The counselor will call at your scheduled time and the entire interview should take 15 to 20 minutes. Questions are broken down into three main categories:

- Activities/health habits
- Occupation
- Medical history

Have the following information available to complete the interview as quickly as possible:

- Names, addresses and phone numbers of medical providers you have visited in the last 10 years*
- The approximate dates of any injuries, surgeries, emergency room visits, hospitalizations, illnesses and/or conditions
- Foreign travel history for the last five years
- If you've been at your current job less than three years, employment information (name of company and dates of employment) for the past five years

A copy of your completed interview is sent to your financial representative and the underwriter assigned to your case. When your representative delivers your policy, carefully review the completed application (with your TeleApp answers included). The application becomes part of your Individual Disability insurance contract. If you have a future claim, an untrue statement could affect payment.

Your TeleApp interview is scheduled for __________ ❑ a.m./ ❑ p.m. on ______________.
Time Date

Please note: Principal Life wants you to be satisfied with your policy. If you are not satisfied for any reason, return the policy to your financial representative or the home office within the first 30 days upon receiving the policy. Principal Life will refund any premiums paid and the policy will be considered void.

* Most states require ten years of medical history; less for some states.

WE'LL GIVE YOU AN EDGE®

Principal Life Insurance Company, Des Moines, Iowa 50392-0002, www.principal.com.

Disability insurance has exclusions and limitations. For costs and complete details of the coverage, contact your Principal Life financial representative. Principal Life is a member of the Principal Financial Group®.

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