

Individual Disability Insurance Application

Thank you for choosing Principal Life Insurance Company to meet your client's disability insurance needs. Please follow the instructions and answer all the questions below to expedite the application process.

Proposed Insured _____

1. Please complete **Part A** of the application and obtain signatures on **Part C**.
2. Please answer all questions legibly and in ink. Any changes should be initialed by the applicant.
3. If applying for Association Sales Program, please contact Jeff Hannemann (1-800-247-9988 x-20992) or (Hannemann.Jeff@Principal.com) to obtain pre-approval.
4. Please submit this Producer Report and all supplemental forms (if applicable) with the application. Please do not duplex the application pages and only print data and wording on one side of a page.
5. Has a TeleApp or Personal Telephone Interview been scheduled? If yes, please provide confirmation number _____. If no, please call 1-888-TeleApp (1-888-835-3277) to schedule the telephone interview and write in the confirmation number above. If using the traditional application process, insured must complete **Part B** (medical questions) on the application. Submit **Part B** with this application.
6. Is an interpreter required for TeleApp?..... Yes No
If Yes, list language: _____
7. Is English the proposed insured's primary language?..... Yes No
(If No, submit Statement of English Understanding form)
8. Please check the Underwriting requirements that have been ordered:

<input type="checkbox"/> HOBP/HOS	Ordered through (Vendor)	_____
<input type="checkbox"/> Urine-HIV	Ordered through (Vendor)	_____
<input type="checkbox"/> Mini/Paramed	Ordered through (Vendor)	_____
<input type="checkbox"/> EKG	Ordered through (Vendor)	_____
<input type="checkbox"/> APS	_____	<input type="checkbox"/> APS _____
<input type="checkbox"/> Cover Letter	_____	<input type="checkbox"/> Other _____
9. Please attach verification of income/financial documentation.
10. Please attach the Premium Summary Report of the DI Illustration. (Attaching this report may expedite underwriting.)
11. If money is taken with the application, give the Conditional Receipt to the applicant/proposed insured. Conditional Receipt coverage cannot take effect unless one month's premium is received. If COD, do not give the Conditional Receipt to the applicant/proposed insured.

Continue to Next Page



Mailing Address:
Des Moines, IA 50392-0001

Principal Life
Insurance Company

Producer Report
Individual Disability

Proposed Insured

12. Case Contact, Contact's Phone Number, Contact's Email Address, Producer Office Name/Number, Unit Office No., Producer's Phone Number

13. List all Producers to Receive Compensation, Tax ID #, Statement/Detail Code, Commission Split (Selling, Servicing), Primary Servicing Producer, Enter Signing Producer's Tax ID # for Corporation or Non-Corporation

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

15. Occupation Class Quoted: 5A, 5A-M, 4A, 4A-M, 3A, 3A-M, 2A, A

16. Discounts (check those that apply)

Multi-Life, Association, Mental/Nervous, Select Occupation, Association Name, Association Number, Employer's Name, Employer's Address, List Bill Number

17. Are funds being submitted with the application? Yes No; If Yes, what is the amount? \$

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

Table with 4 columns: Product, Payment Mode, Mode Premium, Total Annual Premium

20. If special dating 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.

21. Comments or special instructions

- 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.

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



Mailing Address: Des Moines, IA 50392-0001

Principal Life Insurance Company

Disability Insurance Application - PART A

1. PERSONAL INFORMATION ABOUT THE PROPOSED INSURED

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

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) BEING APPLIED 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
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: AIB's 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

- Cost of Living Adjustment 3% max 6% max
Residual Disability Benefit
Short Term Residual Disability Benefit 6 month 12 month
Recovery Benefit 1 year 3 year
Regular Occupation
Extended Total Disability Benefit
Aggregate Benefit Factor 50 75 100
Other

You MUST select ONE of the following:

- Benefit Update (BU) AND Automatic Increase Option (AIO)
Benefit Update (BU) only
Automatic Increase Option (AIO) only
Neither BU nor AIO



Mailing Address:
Des Moines, IA 50392-0001

Principal Life
Insurance Company

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: Individual ____ % 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* EFT*
- * There is an additional charge for premium payment frequencies other than annual.

5. OTHER DISABILITY, ACCIDENT AND SICKNESS INSURANCE

Do you have any other Disability, Accident and Sickness Insurance in force or pending?..... Yes No

If Yes, list all Disability income, Overhead Expense, and Buy-Out coverage in force and all coverage(s) applied for in the past 12 months with all companies including disability benefits provided under group, pension, or retirement plans, salary continuation plans, association plans, credit insurance plans, and any other accident, sickness, or health coverage. Also include coverage for which you will become eligible in the next 3 years after a qualifying period of employment has been met. List the type of coverage in force and indicate if it is individual pay (I) or employer pay (E).

Company	Policy No.	Type of Coverage	Benefit Amt. or % of Income	Elim. Period	Benefit Period	Ind. Pay (I) Emp. Pay (E)		Pending		Replacing	
						<input type="checkbox"/> I <input type="checkbox"/> E	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No			
						<input type="checkbox"/> I <input type="checkbox"/> E	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
						<input type="checkbox"/> I <input type="checkbox"/> E	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
						<input type="checkbox"/> I <input type="checkbox"/> E	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
						<input type="checkbox"/> I <input type="checkbox"/> E	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	

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.



Mailing Address:
Des Moines, IA 50392-0001

**Principal Life
Insurance Company**

**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: _____

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

If using Teleapp, answer question 7 below and proceed to Part C (page 8); 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 had, been treated for, or been diagnosed 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: _____



Mailing Address:
Des Moines, IA 50392-0001

Principal Life Insurance Company
Disability Insurance Application - PART C

AGREEMENT/AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

("Company" means Principal Life Insurance Company)

AGREEMENT: Statements In Application: I represent that all statements in this application are true and complete to the best of my knowledge and belief and were correctly recorded before I signed my name below.

When Insurance Effective: I understand and agree that the Company shall incur no liability unless: (1) a policy issued on this application 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, medical questionnaire, or amendment that becomes a part of this application; 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.

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 and on any medical questionnaire that becomes a part of this application may not be waived.

Form with checkboxes for C.O.D., Overhead Expense, and Disability Buy-Out insurance, including a statement of terms.

AUTHORIZATION: I authorize any doctor, hospital, clinic, health care provider, pharmacy benefit manager, insurance (or reinsuring) company, consumer reporting 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 me to provide to the Company, its representatives, or reinsurers, any such data.

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.

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, 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.

Warning: It is a crime to provide false, misleading, or incomplete information to an insurance company for the purpose of defrauding the company or any other person. Penalties include imprisonment and/or fines and denial of insurance benefits.

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

Signature lines for Proposed Insured, Disability Income, Overhead Expense, Disability Buy-Out, Agent/Broker, and Co-signature, with fields for City, State, and Date.



Mailing Address:
Des Moines, IA 50392-0001

Principal Life Insurance Company | Disability Insurance Application – PART C

AGREEMENT/AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

("Company" means Principal Life Insurance Company)

AGREEMENT: Statements In Application: I represent that all statements in this application 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, including all of its parts, and statements by the Proposed Insured in any medical questionnaire that becomes a part of this application, 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 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, medical questionnaire, or amendment that becomes a part of this application; 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 and on any medical questionnaire that becomes a part of this application 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.

This application is C.O.D. 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.

AUTHORIZATION: I authorize any doctor, hospital, clinic, health care provider, pharmacy benefit manager, insurance (or reinsuring) company, consumer reporting 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 me 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 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, 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.

Warning: It is a crime to provide false, misleading, or incomplete information to an insurance company for the purpose of defrauding the company or any other person. Penalties include imprisonment and/or fines and denial of insurance benefits.

We appreciate your 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 and any named dependents. 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, job, 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, job, income, habits, hobbies and other personal characteristics. We may contact other sources for personal data, including: (1) spouse, (2) roommate, (3) accountant, (4) lawyer, (5) employer, (6) other persons who know you well, (7) insurance companies to which you may have applied for insurance in the past and (8) MIB, Inc. 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 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 will attempt to keep your data confidential. 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 first request within 30 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.

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: Underwriting Officer, Principal Life Insurance Company, Des Moines, Iowa 50392-1620 (Telephone 515-247-5141).

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 Medical Information Bureau, a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the Bureau, upon request, will supply such company with the information in its file.

Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of the Bureau's information office is P.O. Box 105, Essex Station, Boston, Massachusetts 02112, telephone number (617) 426-3660.

With your authorization, Principal Life Insurance Company, or its reinsurers, may also release information in its file to other insurance companies to whom you apply for life or health insurance, or to whom a claim for benefits may be submitted.



Mailing Address:
Des Moines, IA 50392-0001

Principal Life Insurance Company | Disability Insurance Conditional Receipt

(In this 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 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.

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.

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 requirements are completed.

The insurance provided by this Receipt shall be that applied for on the application, 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 on a prepaid basis;
(c) the date we mail the premium payer a premium refund and the proposed owner a notice that no policy will be issued on the application;
(d) the date a policy is presented to the proposed owner (whether or not accepted by the proposed owner).

This Receipt does not commit us to issue any policy. However, in determining whether to issue a policy 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.

CONDITIONS PRECEDENT:

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.
2. The premium deposit must be at least one full month's premium for each policy applied for.
3. The premium deposit must be paid at the time the application is signed, and this Receipt must be issued at the same time.
4. The premium deposit must be received in our Home Office and must be honored on first presentation for payment.

--CONTINUED--

LIMITATIONS:

1. Except as limited by this Receipt, our liability is governed by the terms of the policy(ies) applied for.
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, any supplemental form, or medical questionnaire that becomes a part of the policy. 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.
3. **Disability Income, Overhead Expense, or Disability Buy-Out** – For any claim that occurs at any time after the Start Date and before physical delivery and acceptance of a policy by the owner, any Disability Income, Overhead Expense, or Disability Buy-Out maximum benefit payable will be the lesser of:
 - The amount of benefits applied for in the application;
 - 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); \$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, policy 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 is issued from the application bearing the same date as this Receipt, and the policy is accepted by the proposed owner, we will apply the premium deposit to the first premium due for such policy. If no policy 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 is put in force and no benefit is paid or if a policy 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.



Mailing Address:
Des Moines, IA 50392-0002

Principal Life
Insurance 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 Principal Life Insurance 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 Principal Life. 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 unless prohibited by state and/or federal law the protected health information is to be disclosed under this authorization so that Principal Life 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 Principal Life. *Statement required by §164.508(c)(1)(iv).*

The following groups of persons employed or working for Principal Life may use my personal health information which is described above: employees of the underwriting, administration, claim or legal departments and any other personnel of Principal Life, 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 Principal Life. *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, Des Moines, IA 50392-1780. I understand that a revocation is not effective if Principal Life 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, Principal Life 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).*



Mailing Address:
Des Moines, IA 50392-0002

Principal Life
Insurance 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 Principal Life Insurance 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 Principal Life. 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 unless prohibited by state and/or federal law the protected health information is to be disclosed under this authorization so that Principal Life 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 Principal Life. *Statement required by §164.508(c)(1)(iv).*

The following groups of persons employed or working for Principal Life may use my personal health information which is described above: employees of the underwriting, administration, claim or legal departments and any other personnel of Principal Life, 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 Principal Life. *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).*

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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).*



Mailing Address:
Des Moines, IA 50392-0001

Principal Life
Insurance Company

Notice and Consent Form
for AIDS Virus (HIV)
Antibody/Antigen Testing

Insurer Name	Address
Examiner Name	Address

Acquired Immunodeficiency Syndrome (AIDS) is a life-threatening disorder of the immune system. It is caused by a virus called Human Immunodeficiency Virus (HIV). The virus is spread by sexual contact with an infected person, by exposure to infected blood (as in needle sharing during intravenous drug use or, rarely, as a result of a blood transfusion), or from an infected mother to her newborn infant.

To determine your insurability, the insurer named above (the Insurer) has requested that you provide a sample of your blood for testing and analysis. All tests will be performed by a licensed laboratory.

Unless precluded by law, tests will be performed to determine the presence of HIV antibodies or antigens. 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. Should you desire more information about the test of HIV infection before providing a blood sample, you may wish to consult with your physician or your local health department. If you are at high risk of HIV infection, you may want to be counseled and tested by your physician or at a free/low cost local test site. Your local health department can provide you with information as to the location of these sites.

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, but not to agents and brokers.

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 blood test abnormality. If your HIV test is normal, no report will be made about it to the MIB, Inc.

The organizations described in the last two paragraphs 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 antibody/antigen test results do not mean that you have AIDS, but that you are a 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.

You are urged, at this time, to designate the physician or other health care provider to whom the HIV test results may be disclosed by the Insurer in the event the results are other than normal.

I authorize the disclosure of any HIV test results which are other than normal to the following physician or health care provider:

Name _____

Address _____ City _____ State _____ ZIP _____

I have read and understand this Notice of Consent for AIDS Virus (HIV) Antibody/Antigen Testing. I voluntarily consent to the withdrawal of blood, 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.

X _____ **X** _____
Signature of Proposed Insured or Parent/Guardian Date MM/DD/YYYY

_____ Date of Birth MM/DD/YYYY

_____ State of Residence

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



Mailing Address:
Des Moines, IA 50392-0001

Principal Life
Insurance Company

Notice and Consent Form
for AIDS Virus (HIV)
Antibody/Antigen Testing

Insurer Name	Address
Examiner Name	Address

Acquired Immunodeficiency Syndrome (AIDS) is a life-threatening disorder of the immune system. It is caused by a virus called Human Immunodeficiency Virus (HIV). The virus is spread by sexual contact with an infected person, by exposure to infected blood (as in needle sharing during intravenous drug use or, rarely, as a result of a blood transfusion), or from an infected mother to her newborn infant.

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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, but not to agents and brokers.

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 blood test abnormality. If your HIV test is normal, no report will be made about it to the MIB, Inc.

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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.

X _____ **X** _____
Signature of Proposed Insured or Parent/Guardian Date MM/DD/YYYY

_____ _____
Print Name Date of Birth MM/DD/YYYY

_____ _____
State of Residence

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