

Disability Insurance Application

- Complete initial application (**Part A-Disability Insurance**).
- Obtain signature(s) on **Part C**.
- Call toll free **1-888-835-3277**
(1-888-TELEAPP) to schedule the telephone application interview.
- If using the traditional process, obtain a **Part B** (medical/habits information) from Virtual Supply and insert into this packet.
- For **Overhead Expense and/or Disability Buy-Out**, obtain the appropriate supplemental application from Virtual Supply.
- If money is taken with the application and the disability or overhead expense benefit amount does not exceed \$5,000/month, give the Conditional Receipt to the owner. NOTE: If COD, or if the benefit amount exceeds \$5,000/month, do not take money and do not give the Conditional Receipt to the owner. For Disability Buy-Out, submit all applications on a COD basis and do not give the Conditional Receipt to the owner.



Principal Life Insurance Company
Des Moines, IA 50392-0001

Dear Client

Thank you for applying to The Principal® for your disability insurance needs. The application process is important; please read this page to help you understand it better.

The Telephone Interview

To speed the application process, your representative asked you to complete the insurability questions through a telephone interview.

Your interview is scheduled for _____ a.m./ p.m. on _____
time date

An interviewer from our home office will call you at this time. The entire interview should take 15-20 minutes and covers all the application questions. To complete the interview as quickly as possible, please have the following information available:

1. Names and addresses of physicians or hospitals you have visited in the last 10 years.

2. Names of medications you take or have taken in the past 10 years.

You will be asked to review the application when your representative delivers your policy. Please carefully review the questions and your responses. The application becomes part of your disability insurance contract. If you have a claim, untrue statements could affect claim payment.

How Are Risks Classified?

When you purchase disability insurance from The Principal, you are purchasing protection against financial loss due to a disability. The premium is the amount paid for that protection. How do companies determine how much that premium should be? It is based on fairness.

Fairly priced protection is determined by grouping people who have similar risk characteristics such as age, sex, health, occupation and other factors. Those with similar risk levels pay similar premiums for the protection they choose.

Insurance applications contain a variety of questions and insurers sometimes seek information aside from the application, such as blood profiles or motor vehicle reports. This is done to assure that you pay the most equitable and fair premium for your risk level.

If you have questions about the application process or risk classification, please contact your representative.



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 Smoker Nonsmoker Date of Birth Street Address Birthplace (State or Country) Social Security Number City State Zip Driver's License Number State Occupation/Duties Home Phone Number Work Phone Number

2. DISABILITY INCOME

Disability Income Monthly Amount Elimination Period Benefit Period 1st Adaptable Income Benefit 2nd Adaptable Income Benefit Social Insurance Substitute Benefit Adaptable Income Benefit Your Occupation Period (must select one)

Optional Benefit Riders

Cost of Living 3% 6% Short Term Residual Disability 6 mo. 12 mo. Extended Total Disability Benefit Aggregate Benefit Factor 50 75 100 Residual Disability Regular Occupation Recovery Benefit 1 year 3 year Other Catastrophic Disability Benefit (CDB) Monthly Amount: CDB Elimination Period: CDB Benefit Period:

You MUST select ONE of the following:

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

Owner(s) if other than proposed insured - (Please list owner(s) and have all sign Part C)

Name Address City State Zip Owner Taxpayer ID Number

3. OVERHEAD EXPENSE (Complete Overhead Expense Statement)

Benefit Amount \$ Residual Disability Elimination Period 30-day 60-day 90-day Maximum Aggregate Benefit Factor 12 18 24

You MUST select ONE of the following:

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

Owner(s) if other than proposed insured - (Please list owner(s) and have all sign Part C)

Name Address City State Zip Owner Taxpayer ID Number



Mailing Address:
Des Moines, IA 50392-0001

Principal Life Insurance Company | **Disability Insurance Application**

Proposed Insured _____
Date Of Birth ____ / ____ / _____ Policy Number _____

4. BUY-OUT (Complete Buy-Out Statement)

		<u>Elimination Period</u>	<u>Benefit Period Factor</u>
<input type="checkbox"/> Lump Sum – Benefit Amount	\$ _____	<input type="checkbox"/> 365	<input type="checkbox"/> 24
<input type="checkbox"/> Monthly Payments – Monthly Amount	\$ _____	<input type="checkbox"/> 540	<input type="checkbox"/> 36
		<input type="checkbox"/> 730	<input type="checkbox"/> 60
<input type="checkbox"/> Combination Method (Complete Lump Sum and Monthly Payment Items)			

Owner(s) if other than proposed insured – (Please list owner(s) and have all sign Part C)

Name		Address	
City	State	Zip	Owner Taxpayer ID Number

5. PREMIUM PAYOR AND METHOD OF PAYMENT

a. Premium paid by: Individual Employer
 Insured/Executive Bonus ____ % Employer/Salary Continuation ____ %

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

*If paying other than annually, there is an additional administrative charge included in the amount due. Please refer to your illustration or ask your Licensed Representative what those additional costs are.

6. LOSS PAYEE (if not the owner) FOR DISABILITY INCOME AND OVERHEAD EXPENSE ONLY

Name	Address		
City	State	Zip	

7. 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 (and list any Catastrophic Disability coverage separately), 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) in the "Type of Coverage" column.

Company	Policy No.	Type of Coverage	Benefit Amt. or % of Income	Elim. Period	Benefit Period	Paid to Date	Pending		Replacing	
							Yes	No	Yes	No
							<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
							<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
							<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
							<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Replacement. By signing this application, I agree to terminate the insurance or disability benefits indicated as being replaced within 60 days of the Principal Life policy date. I understand that if I do not cancel or lapse that insurance, Principal Life Insurance Company will rescind this policy.



Mailing Address: Des Moines, IA 50392-0001

Principal Life Insurance Company

Disability Insurance Application

Proposed Insured _____
Date Of Birth ___ / ___ / _____ Policy Number _____

8. 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 Year to Date _____ Last Calendar Year, _____ 2 Years 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 that would end if you become disabled _____

h. Other earned income, specify _____

i. Total Earned Income \$ _____ \$ _____ \$ _____

IF PAPER APPLICATION, STOP HERE AND PROCEED TO PART B - IF TELEPHONE APPLICATION, ANSWER QUESTION 9 AND PROCEED TO PART C.

9. 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, 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 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

Multiple horizontal lines for providing details for question 9a.

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 licensed agent, broker or 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 licensed agent, broker or 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 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, licensed insurance agent, broker or 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.

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 names below. Signatures are required.)

Proposed Insured (*Signature*) _____ Date _____

Owner(s) of Insurance (*Signature*) (If other than Prop. Insured) _____ Title (If corp., officer other than Prop. Insured) _____

Signed at: City _____ State _____ Date _____ Licensed Agent/Broker/Rep. (*Signature*) _____ License Number _____

Cosignature by resident Licensed Agent/Broker/Rep., if applicable, in your state _____ Date _____ License Number _____

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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 licensed agent, broker or 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 licensed agent, broker or 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 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, licensed insurance agent, broker or 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.

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.

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)

\$ _____ \$ _____

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

Licensed Agent/Broker/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 or representative, medical examiner, or telephone interviewer may accept risks, determine insurability, or bind the Company in any way. No licensed agent, broker or 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 licensed agent, broker or representative has **NO AUTHORITY** to accept any premium or to issue this Receipt: 1) if it is apparent that any **Condition Precedent** to coverage under this Receipt is not or cannot be satisfied; 2) in the case of an application for Disability Buy-Out insurance. **This Conditional Receipt shall be ineffective if issued without authority. Only the Home Office, and not the licensed agent, broker or representative, has authority to modify any provisions of this Receipt.**

WHEN THE INSURANCE WILL BECOME EFFECTIVE:

If all of the **Conditions Precedent** set forth in this Receipt are fulfilled exactly, insurance under the terms of the policy, subject to the Limitations set forth in this Receipt, will take effect on the **Start Date**. The **Start Date** is the date upon which all of our initial application requirements are completed. Our initial application requirements consist of full completion and signing of the application (Parts A and C, if using the telephone application process; Parts A, B, & C, if using the paper application process) and all necessary supplements, and any initially required medical exams and tests required by our then current underwriting guidelines and practices.

DATE USED TO DETERMINE INSURABILITY:

We will determine the insurability of the proposed insured as of the **Start Date**. We have until the actual delivery of the policy to make this determination, but we will not consider changes in the proposed insured's health or insurability that occur after the **Start Date**. If an event giving rise to a claim occurs at any time before physical delivery and acceptance of a policy by the owner, benefits payable for such claim are subject to all of the Limitations set forth in this Receipt. If an event giving rise to a claim occurs at any time after physical delivery and acceptance of the new policy by the owner, the claim will be considered solely under the policy. 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:

All the following conditions must be fulfilled exactly before any insurance becomes effective.

1. Full completion and signing of the application and all necessary supplements and all initially required medical exams and tests have been completed within 60 days of the date of this Receipt.
2. On the **Start Date**, the Proposed Insured must be insurable, as determined by our underwriters under our then current underwriting guidelines and practices. If a condition affecting such insurability existed in fact on the **Start Date**, it shall be considered in the determination of insurability.
3. The premium deposit must be at least one full month's premium for each policy applied for.
4. The premium deposit must be paid at the time the application 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--

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 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. 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 or representative, medical examiner, telephone interviewer, or other person shall be considered knowledge of the Company unless such fact is stated in the application.
3. If a policy is not issued within 75 days of the **Start Date**, the application will be deemed rejected, all premium will be refunded to the premium payer, and a notice will be sent to the proposed owner that no policy will be issued on the application.
4. **Disability Income, Catastrophic Disability Benefit, or Overhead Expense Insurance** – 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, Catastrophic Disability Benefit, or Overhead Expense maximum monthly 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 (Disability Benefit and Social Insurance Substitute Benefit); \$5,000 (Overhead Expense Benefit); \$2,500 (Catastrophic Disability Benefit).If the owner refuses physical delivery of the policy, no benefit is payable and this receipt is void. Any premium paid for the policy will be refunded to the premium payer.
5. There is no Conditional Receipt coverage for Disability Buy-Out insurance.

PREMIUMS:

If a policy is issued from this application 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 the premium deposit 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.

Proposed Insured _____ Date _____

Field Case Contact _____ Contact Tele. No. _____ Contact Email Address _____

Field Office Name/Number _____ Sub Office No. _____ Producer's Tel. No. _____

1. 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				

2. Proposed insured's relationship to the producer/licensed representative: _____
3. Is the proposed insured a U.S. Citizen?..... Yes No
 (If No, submit Confidential Non-U.S. Citizen Questionnaire)
4. Is English the proposed insured's primary language? Yes No
 (If No, submit Statement of English Understanding)
- Is an interpreter required for Tele-App or Personal Telephone Interview? Yes No
 If Yes, list language: _____

5. List underwriting requirements ordered by field:
- Tele-APP/PTI Confirmation #: _____
If not scheduled, please call 1-888-TeleApp and schedule at this time.
- HOBP/HOS Ordered through (Vendor Name): _____
- Mini Ordered through (Vendor Name): _____
- EKG Ordered through (Vendor Name): _____
- APS: _____ Cover Letter
- APS: _____ Other: _____

6. Premium submitted by: Owner Insured Business
7. Send premium notices to (if other than the owner): _____

8. a. Non-List Bill Mode: Annual Semi Annual Quarterly Pre-authorized Withdrawal
- b. List Bill Mode: Annual Semi Annual Quarterly Monthly
- List Bill Number (if existing): _____ Billing Address: _____

9. Settlement: C.O.D. Cash \$ _____
- Credit of \$ _____ from policy _____ Salary deduct \$ _____

10. If special dating essential, indicate policy date desired: _____. If settlement taken with application, no requests for advance dating honored except to conform with established Electronic Fund Transfer date.

11. Product	Total Annual Premium	Mode	Mode Premium
_____ / _____	_____ / _____	_____ / _____	_____ / _____
_____ / _____	_____ / _____	_____ / _____	_____ / _____
_____ / _____	_____ / _____	_____ / _____	_____ / _____

12. Occupation Class (check one): 5A 5A-M 4A 4A-M 3A 3A-M 2A A

13. Discounts (Mark those that apply):
- Employer (List Bill) Mental/Nervous Select Occupation

--CONTINUED--

Comments

The answers to each question of this application were recorded in my presence exactly as given. I know nothing detrimental to the risk that is not recorded on this form. I request distribution of commissions as indicated in the Field Office Report.

Signed at:				Producer/Licensed Representative
City	State	Zip	Date	(signing app as witness)
_____	_____	_____	_____	_____



Principal Life Insurance Company | Princor Financial Services Corporation
 Mailing Address: Des Moines, IA 50392-0001

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 Life Insurance Company. Your initial mutual fund check should be payable to Princor Financial Services Corporation. Current mutual fund shareholders should enclose the account identification form from your last statement. Please Note: if this form is used for both mutual fund and life insurance, there will be two separate withdrawals from the account.

Terms and Conditions

1. Withdrawals or electronic fund transfers for mutual fund purchase amounts and existing Principal Life Insurance Company 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
 Flex Draw Date to _____
 Add to Present Plan No. _____
 Change of Institutions or Accounts
 (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 Life Insurance Company and/or Princor Financial Services Corporation (hereafter referred to as "Companies" to debit my account as needed to pay premiums and/or purchase shares of mutual funds.				
Name of Financial Institution			Phone	
			()	
Address		City	State	ZIP
Depositor's Name(s)		Transit and Routing No.		Account No.

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.

City	State	Date MM/DD/YYYY
X	X	
Signature of Depositor	Signature of Joint Account Holder	