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

Application for Disability Insurance Benefit Update Offer/ Future Benefit Increase Offer

1. Name of Insured | Policy Number

2. Employer | Occupation/Duties

3. Report past income as shown on Federal Income Tax Return.

Earned Income:	Year to Date	Actual Last Year
a. Salary, Wages, Commissions & Bonus (W-2 and/or 1099 Form)	$	$
b. Sole-Proprietor (Net income on Form 1040, Schedule C)		
c. Partner or member of Limited Liability Company (LLC) (Schedule K-1 or Form 1040, Schedule E)		
d. Owner of S-Corp or C-Corp (Schedule K-1 or Form 1040, Schedule E, or Pro rata share of C-Corp net profits per Form 1120)		
e. Pension and Profit Sharing Contributions		

4. **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: _____

5. **Net Worth** – Is net worth, excluding primary residence, greater than $6,000,000? ..... ☐ Yes ☐ No
If Yes, itemize: _____

6. **Premium Payor**
   a. Premium paid by: ☐ Insured _____ % ☐ Employer _____ %
   b. If your employer pays any part of the premium, is it reportable by you as taxable income?..... ☐ Yes ☐ No

7. **Other Coverage** – Do you have any other Disability Coverage in force other than this policy? ..... ☐ Yes ☐ No

If yes, please describe all disability coverage in force, other than this policy. Indicate if it is: **A) Individual, B) Association, C) Group, D) Salary Continuation, E) Overhead Expense, or F) Buy-Out**. Please include coverage for which you will become eligible in the next 3 years after a qualifying period of employment has been met.

Company or Source	Type (A, B, C, etc.)	Monthly Benefit Amount	Elim. Period	Benefit Period	Will Coverage Be Replaced?	Effective Date of Cancellation
					☐ Yes ☐ No	
					☐ Yes ☐ No	
					☐ Yes ☐ No	

Authorization

I represent that all statements in this application are true and complete to the best of my knowledge and belief. I have submitted no money with this application. I understand that the statements in this application are the basis of this Benefit Update Offer/Future Benefit Increase Offer. I have received a copy of "Notice of Insurance Information Practices". It includes notice required by any Fair Credit Reporting Act and describes Medical Information Bureau, Inc. (MIB, Inc.). I authorize the release of any records or knowledge of me from any insurance company, institution, person, organization, or MIB, Inc. to the Principal Life Insurance Company and/or its reinsurers. This authorization shall be valid for 24 months from the date of this application. A copy of this authorization shall be as valid as the original.

For your protection, California law requires the following to appear on this form:

Warning: Any person, who knowingly presents false or fraudulent information on an application for insurance, or a false or fraudulent claim for the payment of a loss, is guilty of a crime and may be subject to fines and confinement in state prison.

Notice: If you choose to work at any occupation, you will not be considered Totally Disabled under this policy, but you may qualify for Residual Disability benefits if this rider is attached to your policy.

Signature and Title of Owner (if other than Insured) | Signature of Insured

Signed at: City | State | Date