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

Individual Disability Producer Report

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

Proposed Insured Name		Date
Field Office Contact	Contact Telephone Number	Contact Email Address
Field Office Name	PFG field office # (if known)	Producer's Telephone Number

2. Compensation Information

Print FULL name of all Producers to Receive Compensation	Producer's SSN/Tax ID # (last 4 #s required)	Solicitor/Detail Code	Corp Paid Thru (If Applicable)	Firm/Corp./BGA Tax ID # (If Applicable)	Commission Split
Example: Jonathan Adam Doe	XXX-XX-XXXX	00002-12345	ANY Financial	XX-XXXXXXX	100%

2a) Proposed Insured's relationship to the Producer/Licensed Representative: __________

2b) If related applications were submitted, please list the other proposed insureds: __________

3. Sales Program

☐ New Issue ☐ Adjustment

☐ Individual ☐ GSI ☐ Multi Life ☐ Core Value

4. Underwriting Requirements

Teleapp

Has a Tele-App interview with The Principal® been scheduled to complete Part B / II? ☐ Yes ☐ No

If Yes, Tele-App confirmation # __________

If No, call 1-888-TELEAPP to schedule an interview.

If you'd like The Principal to schedule the Tele-App interview, when is the best time to contact the proposed insured?

Day/Date __________ Time ______ ☐ AM ☐ PM Phone Number __________

Has a PTI (Personal Telephone Interview) with The Principal been scheduled? ☐ Yes ☐ No

Labs

Would you like for us to order? ☐ Yes ☐ No

Which Paramed Provider will complete the routine medical underwriting requirements? (check one)

☐ APPS ☐ ExamOne ☐ Portamedic ☐ Other __________

List underwriting requirements ordered: __________

Is English the Proposed Insured's primary language?) ☐ Yes ☐ No

(If No, submit **Statement of English Understanding** form)

Occupation Class Quoted: ☐ 6A ☐ 6A-M ☐ 5A ☐ 5A-M ☐ 5A Select ☐ 4A ☐ 4A-M ☐ 3A ☐ 3A-M ☐ 2A ☐ A

Is proposed insured in a resident/fellow program? ☐ Yes ☐ No

Prelim Inquiry Completed? ☐ Yes ☐ No If Yes, # __________

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

5. Discount Information

Multi-Life/Affiliation/Association

a. ☐ Existing/Multi Life Number ______________ or ☐ New ______________________________

Employer Name ____ Employer Tax ID ________________________

Employer Address ____

Initial Billing sent to (applicable to Employer billed cases only) ☐ Producer ☐ Employer

☐ Mental/Nervous if a new multi-life case (applies to all lives)

b. Affiliation Type ☐ 1099 Business/Firm ☐ Franchise Owner(s) ☐ Spouse ________________________

c. Association Number (if known) ____

Association Name ____

☐ Mental/Nervous if a new association cases (applies to all lives)

6. Additional Information

a. Illustration Includes ☐ Business Allowance Section 179 Allowance $ ____________________

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

7. Agent / Insurance Producer/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 / Insurance Producer) as applicable prior to/at the time the Customer (Owner) signed the application.

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

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

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

Disability Insurance Application – PART A

1. Personal Information about the Proposed Insured

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

Have you smoked cigarettes or used a nicotine patch or gum within the past 12 months? .... ☐ Yes ☐ No

Are you a U.S. citizen? ☐ Yes ☐ No If no, submit Confidential Non-US Citizen Questionnaire.

2. Indicate Coverage(s) Applying For

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

3. Disability Income

Monthly Benefit Amount: $ ______________
Elimination Period: ☐ 60 day ☐ 90 day ☐ 180 day ☐ 365 day
Benefit Period: ☐ 2 year ☐ 5 year ☐ to age 65 ☐ to age 67 ☐ to age 70
Your Occupation Period: ☐ 2 year ☐ 5 year ☐ to age 65 ☐ to age 67 ☐ to age 70
SIS Monthly Benefit: $ ______________ SIS Benefit Period must equal Base Benefit Period.
SIS Elimination Period: ☐ 30 day ☐ 60 day ☐ 90 day ☐ 180 day ☐ 365 day
Adaptable Income Benefits (AIB) **Note: AIBs program monthly benefits around other in-force coverage**
1st AIB Monthly Benefit: $ ____________ from day ________ to day ________
2nd AIB Monthly Benefit: $ ____________ from day ________ to day ________
SIS AIB Monthly Benefit: $ ____________ from day ________ to day ________

Optional Benefit Riders

☐ Catastrophic Disability Benefit (CDB) Monthly Amount: $ __________
CDB Elimination Period: ☐ 90 day ☐ 180 day ☐ 365 day
CDB Benefit Period: ☐ 2 year ☐ 5 year ☐ to age 65 ☐ to age 67 ☐ to age 70
☐ Cost of Living Adjustment: ☐ 3% max ☐ 6% max
☐ Recovery Benefit: ☐ 1 year ☐ 3 year
☐ Regular Occupation
☐ Residual Disability Benefit
☐ 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

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

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 ______________

Loss Payee (if other than Owner) for Disability Income Only

Name ______________________ Address ______________________

City ______________________ State ______________ Zip ______________

4. Premium Payor 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, or Credit Insurance plans.

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

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

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

Disability Insurance Application – PART A

Proposed Insured ______________________________ Policy Number (if known) ______________

6. Financial

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

If Yes, itemize: ______________________________

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

If Yes, itemize: ______________________________

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

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

7. Medical Question

a. Within the last five years, have you 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: ______________________________

____

____

____

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

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

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

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

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

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

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

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

(continued on next page)

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

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, insurance agent, broker, licensed representative, employer, family member, friend, neighbor, lawyer, accountant, roommate, or business associate 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 date this authorization is signed. 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.

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.

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

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

Disability Insurance Application – PART C

Agreement/Authorization to Obtain and Disclose Information.

(“Company” means Principal Life Insurance Company)

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

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

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

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

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

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

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

AUTHORIZATION: I authorize any insurance (or reinsuring) company, consumer reporting agency, governmental agency, insurance agent, broker, licensed representative, employer, family member, friend, neighbor, lawyer, accountant, roommate, or business associate 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 date this authorization is signed. 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.

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.

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

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

Insurance Provided:

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

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

(a) 75 days after the Start Date;

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

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

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

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

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

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

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

--CONTINUED--

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

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

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

Limitations:

1. Except as limited by this Receipt, our liability is governed by the terms of the policy(ies) including but not limited to all policy(ies) riders and endorsements.
2. No benefit is payable under this Receipt and this Receipt is void, if there is any incorrect, untrue, incomplete, or omitted statement of material fact in Part A, B, or C of the application(s), any supplemental form, or medical questionnaire(s) that becomes a part of the policy(ies). No knowledge of any fact on the part of any agent, broker, licensed representative, medical examiner, telephone interviewer, or other person shall be considered knowledge of the Company unless such fact is stated in the application(s).
3. **Disability Income, Catastrophic Disability Benefit, Overhead Expense, 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(ies) by the owner, any Disability Income, Catastrophic Disability Benefit, Overhead Expense, or Disability Buy-Out 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); $2,500 per month (Catastrophic Disability Benefit); $500,000 (Disability Buy-Out Maximum Aggregate Benefit).

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

Premiums:

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

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

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:

		Elimination Period	Benefit Period Factor
☐ Lump Sum – Benefit Amount	$ ________	☐ 365 day	☐ 24
☐ Monthly Payments – Monthly Amount	$ ________	☐ 540 day	☐ 36
		☐ 730 day	☐ 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**	$ ________	________	________

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.

I represent that all the above statements in this application are true and complete to the best of my knowledge and belief. I understand that the statements in this application are a part of any insurance issued.

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

X ______________________ ______________ ______ ____/ ____/ ________
Proposed Insured *(Signature)* Signed at: City State Date

X ______________________ ____/ ____/ ________
Witness (Agent/Broker/Licensed Rep.) Date

Mailing Address:
Des Moines, IA 50392-0001

Principal Life Insurance Company

Disclosure of Compensation Statement

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

CLIENT COPY

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

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

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

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

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

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

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

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

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

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

Proposed Insured/Patient Copy – Sign Original

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

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

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

Notice and Consent

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

Information Form For Insurance Proposed Insured

Before consenting to testing, please read the following information:

To evaluate your insurability, the above company (the Insurer) has requested that you be tested. 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 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 lymph 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

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®.

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.

Pre-Testing Conditions:

Many public health organizations have recommended that before taking an AIDS-related test a person seek counseling to become informed concerning the implications of such a test. You may wish to consider counseling, at your expense, prior to being tested. A list of counseling resources is provided to you with this form.

Consent

I have read this Notice and Consent and I have received a copy of the counseling resource list. I voluntarily consent to this testing and the disclosure of the test results as described above. I have read the information on this form about what a test result means and understand that I should contact a local AIDS service group or my private physician for further information and counseling if the test result is positive.

Name of Physician for reporting possible positive result

Address	City	State	ZIP

There is also a form inside the lab 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

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.

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

Notice and Consent

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

Information Form For Insurance Proposed Insured

Before consenting to testing, please read the following information:

To evaluate your insurability, the above company (the Insurer) has requested that you be tested. 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 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 lymph 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

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®.

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.

Pre-Testing Conditions:

Many public health organizations have recommended that before taking an AIDS-related test a person seek counseling to become informed concerning the implications of such a test. You may wish to consider counseling, at your expense, prior to being tested. A list of counseling resources is provided to you with this form.

Consent

I have read this Notice and Consent and I have received a copy of the counseling resource list. I voluntarily consent to this testing and the disclosure of the test results as described above. I have read the information on this form about what a test result means and understand that I should contact a local AIDS service group or my private physician for further information and counseling if the test result is positive.

Name of Physician for reporting possible positive result

Address	City	State	ZIP

There is also a form inside the lab 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

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.

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

Counseling Resources

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

COUNSELING RESOURCES LIST

Public health authorities urge that everyone become educated about how to protect themselves from HIV infection. If you have questions or concerns, your own physician or health care provider is your best source of information. Other counseling services may also be available to you.

This is not a complete list of all resources that may be available to you. We suggest you contact your own physician or health care provider, your county health department, or your local chapter of the American Red Cross, for further information.

Regents’ of U.C., San Francisco
1001 Potrero, Ward 60, Room 11
San Francisco, CA 94110

Northeast San Diego Health Plan
San Diego County
408 Cassidy Street
Oceanside, CA 92056

Planned Parenthood of San Diego/ Riverside Counties
2100 Fifth Avenue
San Diego, CA 92101

Los Angeles Regional Family Planning Council
3250 Wilshire Blvd., Ste. 320
Los Angeles, CA 90010

Vista Community Clinic
San Diego County
981 Vole Terrace
Vista, CA 92086

Buttonwillow Health Center
Kern County
P.O. Box 917-277
Buttonwillow, CA 93206

Y.W.C.A. Health Services
Alameda County
1515 Webster Street
Oakland, CA 94612

Planned Parenthood of Central California
255 N. Fulton, Ste. 104
Fresno, CA 93701

Planned Parenthood of Santa Barbara County
518 Carden Street
Santa Barbara, CA 93101

Episcopal Community Services
San Diego County
3425 Fifth Avenue
San Diego, CA 92103

Logan Heights Family Health Center
San Diego County
1809 National Avenue
San Diego, CA 92113

Planned Parenthood of Sacremento Valley
501 “S” Street, #3
Sacremento, CA 95814

Planned Parenthood of Santa Cruz County
212 Laurel Street
Santa Cruz, CA 95060

Planned Parent Association of Santa Clara County
1691 The Alameda
San Jose, CA 95126

Planned Parenthood of Alameda/ San Francisco
815 Eddy Street, Ste. 300
San Francisco, CA 94109

Bench Area Community Clinic
San Diego County
3705 Mission Blvd.
San Diego, CA 92109

Fresno County EOC
Fresno County
2100 Tulare Street
Fresno, CA 93721

Planned Parenthood of Marin and Sonoma Counties
20 “II” Street
San Rafael, CA 94901

North County Health Services
San Diego County
348 Roncheros Drive
San Marcos, CA 92069

Sonoma County People for Equal Opportunity
Sonoma County
930 Piper Road
Santa Rose, CA 95401

Our Health Center
Santa Clara County
270 Grant Avenue
Palo Alto, CA 94306

Planned Parenthood of San Mateo
2211 Plam Avenue
San Mateo, CA 94403

National Medical Assoc.
San Diego County
3177 Oceanview Blvd.
San Diego, CA 92113

Laguna Beach Community Clinic
Orange County
364 Ocean Avenue
Laguna Beach, CA 92651

Huntington Beach Community Clinic
Orange County
322 Fifth Street
Huntington Beach, CA 92648

Planned Parenthood of Contra Costa County
1291 Oakland Blvd.
Walnut Creek, CA 94596

Linda Vista Health Care Center
San Diego County
6973 Linda Vista Road
San Diego, CA 92111

Salud Pura La Cente
10 Alexander Street
Watsonville, CA 95076

Alliance Medical Center
Sonoma County
P.O. Box 982
Healdsburg, CA 95440

La Clinica De La Paza
Alameda County
1515 Fruitvale Avenue
Oakland, CA 94601

Valley Community Health Center
Alameda County
4361 Railroad Avenue
Plenanoton, CA 94566

Youth Projects, Inc.
San Francisco City/County
1696 Haight Street
San Francisco, CA 94110

San Francisco AIDS Foundation
25 Van Nena Avenue
Suite 660
San Francisco, CA 94102
(415) 864-5855

Sacramento AIDS Foundation
1900 K Street
Suite 201
Sacramento, CA 95814
(916) 448-2437

Central Valley AIDS Team
P.O. Box 4640
Fresno, CA 93744
(209) 264-2436

AIDS Project Los Angeles
3760 Wilshire Blvd.
Suite 300
Los Angeles, CA 90010
(213) 380-2000

AIDS Services
Foundation of Orange County
1685-A Babcock St.
Costa Mesa, CA 92627
(714) 646-0411

San Diego AIDS Project
3777 Fourth Avenue
San Diego, CA 92103
(619) 543-0300

AIDS Project – East Bay
400 40th Street
Suite 20
Oakland, CA 94609
(415) 420-8181

ARIS Project
595 Millich Drive
Suite 104
Campbell, CA 95008
(408) 370-3272

West Contra Costa Community Health
Contra Costa County
101 Broadway
Richmond, CA 94804

Imperial Beach Community Clinic
San Diego County
154 Palm Avenue
Imperial Beach, CA 92032

Orange County Center for Health
Orange County
503 N. Anaheim Blvd.

Aquarinn Effort, Inc. Sacramento County
1304 “O” Street
Sacramento, CA

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 Life Insurance Company

P.O. Box 14455
Des Moines, IA 50306-0431

Authorization for Withdrawals and/or Electronic Fund Transfers (IDI New Issue Policies only)

FOR INDIVIDUAL DISABILITY NEW ISSUE POLICIES ONLY

NOTE: We are unable to draw funds if any of the required fields marked with an asterisk (*) are left blank, incomplete, or if this form is not signed. Any Conditional Receipt coverage will be void. Refer to the Conditional Receipt (AA1751/AA2250 as applicable) for terms and conditions.

*Choose ONE of the following:

☐ **Initial Modal Premium Only (Quarterly, Semi-Annual or Annual)**
I authorize an immediate draft for the initial premium payment. Can also be used for Monthly Non-Recurring EFT.

☐ **Initial Monthly Premium with Monthly Recurring EFT**
I authorize an immediate draft for the initial premium payment, and future recurring monthly EFT premiums, including any premium needed if policy is backdated. Premium notices will not be mailed.

☐ **Initial Modal Premium (Quarterly, Semi-Annual or Annual), including Shortage of Premium**
I authorize an immediate draft for the initial premium payment. Any applicable premium shortage will be drawn when all delivery requirements are received. Can also be used for Monthly Non-Recurring EFT.

☐ **Initial Monthly Premium, including Shortage of Premium with Monthly Recurring EFT**
I authorize an immediate draft for the initial premium payment. Any applicable premium shortage will be drawn when all delivery requirements are received. We will continue to draft for future recurring monthly EFT premiums, including any premium needed if policy is backdated. Premium notices will not be mailed.

☐ **Monthly Recurring EFT Only**
I authorize recurring monthly EFT premiums, including any premium needed if policy is backdated. Premium notices will not be mailed.

If Initial Modal/Premium and Monthly Recurring EFT are to be drafted from different accounts, complete a separate form for each.

*Type of Account:

☐ **Checking** (see below)

☐ **Savings** – (A statement or letter from the bank is required authorizing the draft from a savings account. The account and routing number must be referenced.)

Sample Check

JOHN OR JANE DOE
B) Bank Routing Number
0123 (Check No.)
A) ACH Routing Number
Date
Pay to the order of
$
Dollars
ACH R/T 012345678
C) Account Number
Memo
:: 012345678 :: 0000012345678" 0123 (Check No.)

Complete Your Bank Information Below, or Submit Voided Check

***A) ACH Routing Number** (Only if listed on your check)

____

***B) Bank Routing Number** (This number is the first 9 numbers. Please do not include any alpha or special characters)

____

***C) Account Number** (Include all preceding zeros on your account number)

____

*Insured Name or Policy No.(s)				
*Amount	$	$	$	$

I authorize the financial institution named below to honor withdrawals and/or electronic fund transfers by the Company listed above. The draft request to the financial institution must be honored on first presentment. I understand if the withdrawal requests are dishonored by the Company, whether with or without cause, that the Company shall be under no liability. This authorization will be in effect until cancelled either by myself, the Company or the financial institution. Any applicable refunds will be refunded back to the premium payer in the form of a check.

X ___________________________ Signature of Bank Account Holder | ___________________________ Bank Account Holder's Name (Printed) | ____________ Date (MM/DD/YYYY)

X ___________________________ Signature of Joint Bank Account Holder | ___________________________ Joint Bank Account Holder's Name (Printed) | ____________ Date (MM/DD/YYYY)

Insurance products from the Principal Financial Group® (The Principal®) are issued by 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 LIFE INSURANCE COMPANY

DISABILITY BUY-OUT PROTECTION COVERAGE

REQUIRED DISCLOSURE STATEMENT

(Outline of Coverage for Disability Buy-Out Policy Form HH673CA)

READ YOUR POLICY CAREFULLY: This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract, and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR POLICY CAREFULLY.

DISABILITY BUY-OUT PROTECTION COVERAGE: Policies of this category are designed to provide, to Owners of these policies, coverage for Buy-Out Expenses resulting from the Total Disability of the Insured due to covered Injury or Sickness, subject to any limitations set forth in the policy. Coverage is not provided as income replacement for the Insured.

POLICY DATA

BUY-OUT EXPENSE BENEFIT:

Elimination Period:

Days: ________________________

Payment Method (Check one and complete.)

☐ Monthly Payment Method

Maximum Monthly Benefit $ ________________________

Maximum Aggregate Benefit $ ________________________

☐ Lump Sum Payment Method

Maximum Lump Sum Benefit $ ________________________

Maximum Aggregate Benefit $ ________________________

☐ Combination Payment Method

Maximum Lump Sum Benefit $ ________________________

Maximum Monthly Benefit $ ________________________

Maximum Aggregate Benefit $ ________________________

For a Total Disability beginning on or after the Insured's Age 61 Policy Anniversary, the benefit provided will be reduced.

BUY-OUT EXPENSE-- means the expense incurred by the Owner in the performance of the terms of the Buy-Sell Agreement in effect when the Insured's Total Disability began.

TOTAL DISABILITY-- means solely due to Injury or Sickness the Insured is:

1. Unable to perform the substantial and material duties of the Regular Occupation;

2. Not working in any other occupation for the Firm; and

3. Is receiving Doctor's Care for that Injury or Sickness. We will waive this requirement when we receive proof satisfactory to us that continued care would be of no benefit.

We will waive the requirements of Total Disability during the Insured's lifetime after a payment of a Buy-Out Expense benefit has been made.

ELIMINATION PERIOD-- means the number of days of Total Disability that must elapse before benefits become payable.

BUY-SELL AGREEMENT-- means the written agreement between the Insured and the Owner establishing the purchase of the Insured's ownership interest in the Firm in the event of the Insured's Total Disability. The Buy-Sell Agreement must be in force at the time Total Disability begins in order to receive a benefit.

IN THIS POLICY THE:

1. Buy-Out Expense Benefit pays only under the applicable payment method shown above:

   a. Monthly Payment Method pays an amount equal to the lesser of the actual monthly Buy-Out Expense the Owner incurs or the Maximum Monthly Benefit shown on page 1.

   b. Lump Sum Payment Method pays an amount equal to the lump sum Buy-Out Expense the Owner incurs or the Maximum Lump Sum Benefit shown on page 1.

   c. Combination Payment Method is a combination of the Monthly Payment and Lump Sum Payment Methods. We will pay an amount equal to the lesser of the actual lump sum Buy-Out Expense the Owner incurs or the Maximum Lump Sum Benefit shown on page 1. After the lump sum benefit is paid, monthly payments will begin. The monthly amount payable is equal to the lesser of the actual monthly Buy-Out Expense the Owner incurs or the Maximum Monthly Benefit shown on page 1.

2. Waiver of Premium Benefit waives (or refunds if already paid) premiums after the Insured has been Totally Disabled for 90 consecutive days.

3. Legal Fee Benefit pays the Owner for legal fees incurred in performance of the Buy-Sell Agreement as a result of the Insured's Total Disability.

4. Special Death Benefit pays an additional amount if the Insured dies while a monthly Buy-Out Expense Benefit is being paid.

POLICY LIMITATIONS

1. PRE-EXISTING CONDITION LIMITATION

   We will not pay any claim for a Disability or loss which:

   a. Results from a pre-existing condition which was not disclosed in the policy's application; and

   b. Begins within 2 years prior to the application or 2 years after the date of application.

   Pre-existing condition means a condition:

   a. For which medical treatment was recommended by a Doctor or received from a Doctor within the 2 year period prior to the date of the application; or

   b. Which has caused symptoms within the 2 year period prior to the date of the application which would cause an ordinarily prudent person to seek diagnosis, care, or treatment.

   Total Disability from a Sickness or physical condition fully disclosed on the application will be covered unless excluded by name or specific condition.

2. Your policy will be suspended while you are on full-time active duty in the military service. We will refund the pro rata portion of any premium paid beyond the date of suspension. If active duty ends within 5 years from the date of suspension, the Owner applies in writing to restore the policy and premiums are paid within 90 days following the date active duty ends, your policy may be restored. The restored policy will only cover a Disability from a Sickness which first manifests itself or Injury which first occurs after the policy is restored.

3. If a Total Disability is caused by more than one Injury or Sickness, benefits will be paid as if caused by one.

4. We will not use any misstatement in the application to void the policy or deny a claim after the policy has been in force for three years during the Insured's lifetime.

YOUR RIGHT TO CANCEL

You have ten days to review the policy. If you decide you don't want to keep it, send it back to the agent or Company within ten days of receiving it and you will get a refund of all premiums you have paid.

ADDITIONAL BENEFIT RIDERS

☐ BENEFIT UPDATE RIDER. This offers to adjust your benefit every three years to the maximum we would issue according to your then current situation and our rules. You need not show evidence of good health. No offers will be made after your Age 55 Policy Anniversary, except one offer will be made for any policy issued on or after age 52.

☐ EMPLOYMENT IN THE FIRM RIDER. The definition of Total Disability is changed to mean solely due to Injury or Sickness the Insured is:

1. Unable to perform the substantial and material duties of the Regular Occupation; and

2. Receiving Doctor's Care. We will waive this requirement when we receive proof satisfactory to us that continued care would be of no benefit.

PREMIUM INFORMATION

Total Annual Premium

To Age 65 Policy Anniversary $ ________________________

Premium Payable (Mode)

To Age 65 Policy Anniversary $ ________________________

Premiums are guaranteed for the lifetime of the policy. A grace period of 31 days is allowed after the premium due date to pay the premium due.

THE ANTICIPATED LOSS RATIO FOR THIS POLICY IS 55%.

Submitted by: ______________________________________

Date: ____

President and Chief Executive Officer

Principal Life Insurance Company
Des Moines, Iowa 50392-0001

Principal Life
Insurance Company
Des Moines, Iowa 50392-0001

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. With your authorization, we may also provide data to: (1) MIB, Inc.; (2) other insurance companies; or (3) our reinsurers, if needed to secure reinsurance. In some circumstances your information may be disclosed without a need for authorization and in accordance with applicable law to: (1) federal and state agencies and others, if required by law; (2) an insurance regulatory authority; or (3) others conducting actuarial or research studies on our behalf anonymously, as permitted by law.

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. You may be charged a fee for any copies of your data. You have the right to know what information we have on file about you. You have the right to know the specific information leading to an adverse underwriting decision and the source of that information. In the event of an adverse underwriting decision you have the right to request in writing, within 90 business days, the specific reasons for the 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. Within 21 days from the date we receive your request, we will furnish you and/or your doctor the specific reasons for our decision and the specific items in your file that support the decision that you are entitled to receive. You have the right to correct or amend any data in your file. Any request for correction or amendment must be in writing. Within 30 days of receipt of your written request, we will notify you of our correction, amendment or deletion of the information in dispute, or our refusal to make such correction, amendment or deletion of the information after further investigation. In the event that we refuse to correct, amend or delete the information in dispute, you have the right to submit to us a written statement of the reasons for your disagreement with our assessment of the information in dispute and what you consider to be the correct information. We will make such a statement accessible to any and all parties reviewing the information in dispute.

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).

— CONTINUED —

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

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.

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

Mailing Address:
PO Box 10431
Des Moines, IA 50306-0431

Principal Life Insurance Company

Supplemental Statement

Name	Date of Birth	Date Application Signed	File Number(s)

☐ Yes ☐ No 1. Have you or any person proposed for insurance had any illness or injury or consulted a member of the medical profession since the date of application? If yes, provide details ______________

☐ Yes ☐ No 2. (Disability Insurance only) Have you changed jobs or employment since the date of application, or do you intend to change jobs or employment within the next 6 months? If yes, provide details

☐ Yes ☐ No 3. Have you applied for other life, disability or health insurance since the date of application? If yes, please provide details including carrier name, action taken and the intent of the coverage that was was applied for with the other carrier. ______________

I represent that all statements recorded above 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 they will become part of my application and any policy issued on it.

Signature of Proposed Insured (If age 15 or over)

X

Signature of Parent (If Proposed Insured is under age 18)

X

Date	Signature of Licensed Agent/Broker/Representative	License Number
	X	

Individual Disability Insurance

TeleApp Interview

Congratulations! You've taken an important step in protecting your income. 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 interview

A Principal Life TeleApp counselor will call you at your scheduled time and the interview should take only 15 to 20 minutes.

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

Questions are broken down into three main categories:

1 Activities/health habits **2 Occupation** **3 Medical history**

To complete the interview as quickly as possible, have the following information ready:

- 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 from 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

Next steps

When completed, a copy of the 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, a false statement could affect payment.

If you have questions or would like more information, please contact your financial representative.

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 10 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 coverage details, contact your Principal Life financial representative.

JJ1296APP-01 | 12/2015 | © 2015 Principal Financial Services, Inc.