Producer Report

Individual Disability Insurance
For Advisor/Field Office use

Principal®

Page 1 Instructions: Complete all sections (A-E)

A. Proposed Insured Information

Name	Phone Number	Email

B. Field Contact and Office Information

Field Office Contact (FOC)	FOC Phone Number		FOC Email
Field Office Name	Principal Office #:	Advisor Phone Number	Advisor Email

C. Advisor/Compensation Information

Advisor's full name(s) *First advisor listed will become the Servicing Advisor*	Advisor SSN *Last 4 #s required*	Principal assigned detail number/code. *If unknown, list office you write Principal business through*	Are you signing on behalf of a corp/firm, if yes provide name	Corp/Firm Tax ID # *if applicable*	Commission Split
Example: Jonathan Adam Doe	**XXX-XX-XXXX**	**0002-12345**	**ANY Financial**	**XX-XXXXXXX**	**100%**

D. Underwriting Requirements

1. **TeleApp Interview** *(Part B of application)*
   a. Has a Principal® TeleApp interview or PTI been: ☐ Scheduled ☐ Completed
   If TeleApp interview has not been scheduled, call 1.888.TeleApp (888.835.3277) to schedule an interview or go to Principal.com/teleapp
2. **Labs Requirements**
   a. Have labs been ordered? ☐ Yes ☐ No
   b. If Yes, which Paramed provider will complete the routine medical underwriting requirements?
   ☐ APPS ☐ ExamOne ☐ Other *(select one)*
   Lab ticket number *(if known)*: _____
   Which state will the exam take place? _____
3. Is English the proposed insured's primary language? ☐ Yes ☐ No
   (If no, the **Statement of English Understanding** form DD992A is required)
4. Occupation class quoted:
   ☐ 6A ☐ 5A ☐ 5A-Select ☐ 4A ☐ 3A ☐ 2A ☐ A
   Medical classes: ☐ 5A-M ☐ 4A-M ☐ 3A-M
5. Are you applying through Select Professional program limits? ☐ Yes ☐ No
6. Was a prelim inquiry completed? *(please include email from Underwriter)* ☐ Yes ☐ No

E. Additional Information

1. If special dating is desired, indicate requested policy date: _____
2. Proposed insureds relationship to advisor? _____
3. Is ePolicy desired?* ☐ Yes ☐ No *(*Currently available for Disability Income policies only. Policy packet will be emailed to FOC listed in section B. Once ePolicy is received, print policy packet and obtain ink signatures for delivery.)*

Producer Report

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For Advisor/Field Office use

Page 2 Instructions:

1. Section F – Are you applying for a discount? ☐ Yes ☐ No If no, skip to page 3.
2. Section G – Complete if discount was selected.
3. Section H – ☐ Individual billed – *Skip section H*
   ☐ Employer billed – *Complete Section H*

F. Discount Information

1. Discounts *(select one, if applicable)*
   ☐ Multi-Life *(Requires 3 or more insureds with the same employer and advisor)*
   ☐ Multi-Life Resident *(Requires 3 or more residents/fellows/interns/students in the same medical or dental residency program. Excludes staff physicians.)*
   ☐ Association
   ☐ Affiliation, select type:
      ☐ 1099 business/firm
      ☐ Franchise Owner
      ☐ Family, list names: _____
      ☐ Spouse, list name: _____
2. Is this application part of an existing case or established discount? ☐ Yes *(if yes, skip to question 5)* ☐ No
3. Does discount above include Mental/Nervous limitation rider? *(applies to all lives)* ☐ Yes ☐ No
4. If other applications linked by discount were submitted, list other proposed insureds names: _____
   _____
5. Existing Multi-life/Resident/Association/Affiliation number: _____

G. Employer/Affiliation/Association/Residency Information

Entity Name		Tax ID	
Address	City	State	Zip

H. Billing Information - For employer billed only

Primary Contact	Phone Number	Email Address
Billing Contact	Phone Number	Email Address

1. Select Payment Option: ☐ Check ☐ Monthly EFT* – (form DD9281 required)
   *(*initial payment must be in form of check, then EFT can be set-up)*
2. Will this be on a payroll deduction plan with the employer? ☐ Yes ☐ No
3. Send initial bill to: ☐ Advisor ☐ Employer

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For Advisor/Field Office use

I. Comments or Special Instructions

Examples: Underwriting instructions, cases related by discount or multi-life #, 3rd life to establish discount, etc..

J. Advisor/Licensed Representative Signature

☐ This application was signed by the proposed insured in my presence.
☐ I was not present at the time this application was signed by the proposed insured

I request distribution of commissions as indicated. 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 Advisor) as applicable prior to/at the time the Customer signed the application.

Advisor/Licensed Representative Signature	Signed at: City	State	Zip	Date

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

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P.O. Box 14455
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Disability Insurance Application – PART A

Proposed Insured _____ Policy Number (if known) _____

3. Disability Income (Continued)

Owner (if other than Proposed Insured) – (Please list owner below and sign Part C.)

Name _____ Address _____

City _____ State _____ Zip _____ Owner Taxpayer ID Number _____

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.

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Insurance Company
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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: _____

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

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

7. Medical Question

a. Within the last five years, have you 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
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Disability Insurance Application – PART C

Agreement/Authorization to Obtain and Disclose Information.

("Company" means Principal Life Insurance Company)

AGREEMENT: Statements In Application(s): I represent that all statements in this application(s) are true and complete to the best of my knowledge and 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.

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 National Life Insurance Company
Principal Life Insurance Company
Preferred Product Network, Inc.
Members of Principal Financial Group®

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

Compensation and Relationship Disclosure Statement

Only one company is the issuer and responsible for obligations of any policy.

The member companies of the Principal Financial Group® (The Principal®) offer many different financial products to our customers. These products may be issued by Principal National Life Insurance Company (Principal National), Principal Life Insurance Company (Principal Life) or other insurance carriers through an affiliated company, Preferred Product Network, Inc. (Product Network).

A financial professional associated with Principal National and/or Principal Life as an agent, has a contractual obligation to sell sufficient Principal National and/or Principal Life products to maintain his/her benefit package, which includes health insurance, stock incentives, pension, and other benefits. The financial professional may sell non-Principal National and/or non-Principal Life insurance products primarily offered through Product Network**,** which offers products from other financial services companies. Each insurance product, whether it is a Principal National, Principal Life product, or a product sold through Product Network, may provide for different amounts of compensation (cash or non-cash) to the financial professional or his/her firm. His/her role, as a representative of an issuing insurer, is to assist you in purchasing a financial product.

How are financial professionals compensated for product sales?

Compensation can include sales commission, override compensation, expense allowances, referral fees, servicing fees, and other types of sales related compensation or reimbursements. Compensation (cash or non-cash) may be 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 financial professional may receive this compensation from The Principal and/or entities through which he/she places business.

Product Network also receives compensation for each product a financial professional sells through Product Network.

Other Compensation

Additionally, The Principal may pay compensation to a financial professional (or her/his affiliated entity, broker dealer or firm) when a current or former participant in a retirement plan or an employee covered under an employer sponsored benefit, purchases products available from The Principal with the assistance of an employee or career agent of The Principal.

I acknowledge receipt of this Disclosure Statement. I have received, read and understand it, before making (or before others under my direction make) application for the product(s) under consideration. I understand that application for a product is my approval that the selling financial professional arrange the purchase of the product(s) from Principal National, Principal Life, or through Product Network and receive compensation for the sale.

Print Name of Applicant	
Applicant Signature	Date
Print Name of Joint Applicant (if applicable)	
Joint Applicant Signature (if applicable)	Date
Signature of Licensed Agent/Broker/Representative	Date

(This form is intended for use by Principal agents selling non-securities products. If this sale involves a Principal non-securities product, this disclosure statement must be sent to the home office prior to issuance of a product. If this sale involves a Product Network non-securities product, financial professional should maintain a copy in the customer's file.)

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.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I further understand that My Providers cannot condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this authorization.

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).*

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P.O. Box 10431
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Authorization for Release of Personal Health Information – All States
(Applicable to Individual Life and Disability Insurance Customers)

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CLIENT COPY

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

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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).*

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Proposed Insured/Patient Copy – Sign Original

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

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

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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

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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.

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Confidentiality of Test Results:

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Counseling Resources

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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
PO BOX 14455, Des Moines, IA 50306
www.principal.com

Electronic Fund Transfers
Individual Disability Income
Call: 800.247.9988
Fax: 866.825.4779
Email: diservice@principal.com

Select Payment Mode (Please choose one): ☐ Monthly (ONLY available with EFT) ☐ Quarterly ☐ Semi-Annual ☐ Annual

Policy/Contract Number: _____ **Insured Name:** _____

COMPLETE THIS SECTION FOR: NEW ISSUE POLICIES ONLY

NOTE: We are unable to draw funds if this form is incomplete or unsigned. Any Conditional Receipt coverage will be void. Please refer to the Conditional Receipt (AA1751/AA2250 as applicable) for terms and conditions.

Select all that apply (you must choose at least one):

☐ **Draft initial payment upon receipt of application (Enter amount of draft: $_____):** I authorize an immediate draft for the initial payment as indicated by the selected mode above. Any applicable shortage in payment due will be drawn when all delivery requirements are received.

☐ **Draft payment at delivery:** I authorize a draft for the initial payment (including any shortage due) as indicated by the selected mode above when my policy is delivered.

☐ **Recurring Automatic EFT Payment:** I authorize payments to be drawn on a recurring basis as indicated by the selected mode above. Billing notices will not be mailed for monthly mode.

IF INITIAL AND RECURRING PAYMENTS ARE TO BE DRAFTED FROM DIFFERENT ACCOUNTS, COMPLETE A SEPARATE FORM FOR EACH.

Bank Information:

Special Draw Date (1st – 28th): Enter requested draft date_____
Please note: Depending upon your financial institution, it may take up to three to five business days for the transaction to show in your account.

☐ Checking* Account ☐ Savings* Account *Deposit slips should not be used to verify banking information as routing numbers will vary.

BANK NAME	
ROUTING NUMBER (9 DIGITS)	ACCOUNT NUMBER (INCLUDE ALL PRECEDING ZEROS ON YOUR ACCOUNT NUMBER)
ACCOUNT HOLDER'S NAME	ACCOUNT HOLDER'S PHONE NUMBER
JOINT ACCOUNT HOLDER'S NAME	ACCOUNT HOLDER'S EMAIL ADDRESS

I authorize Principal Life Insurance Company (hereafter referred to as "Company") to debit my account as indicated above.

Authorization Agreement:

I authorize the financial institution named above to honor withdrawals and/or electronic fund transfers by the Company listed above. I understand if any withdrawals are dishonored, whether with or without cause, that the company shall be under no liability. This authorization will remain in effect until cancelled either by myself, the Company, or the financial institution named above. If this form is not dated, it will be effective the date it is received in our Home Office.

_____	_____	_____
Signature of Account Holder (Include title if Corporate owner or "trustee" if Trust owned)	Print Name of Account Holder	Date
_____	_____	_____
Signature of Joint Account Holder (Include title if Corporate owner or "trustee" if Trust owned)	Print Name of Joint Account Holder	Date

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Principal℠

CALIFORNIA PRIVACY NOTICE

This Notice is provided on behalf of the following companies of the Principal Financial Group:
Principal Life Insurance Company
Principal National Life Insurance Company
Principal Trust Company
Principal Life Insurance Company Variable Life Separate Account
Principal National Life Insurance Company Variable Life Separate Account
Principal Life Insurance Company Separate Account B
Employers Dental Services, Inc. / Principal Dental Services, Inc.
First Dental Health

Protecting your privacy

This Notice is required by law. It tells how we handle personal information.

This Notice applies to individual residents of California who:

- own or apply for our products or services for personal use.
- are employee benefit plan participants and beneficiaries.

Please note that in this Notice, "you" refers to only these people. The Notice does not apply to an employer plan sponsor or group policyholder.

We protect information we collect about you

We follow strict standards to protect personal information. These standards include limiting access to data and regularly testing our security technology.

How we collect information

We collect data about you as we do business with you. Some of the sources of this data are as follows:

- **Information we obtain when you apply or enroll for products or services.** You may provide facts such as your name; address; Social Security number; financial status; and, when applicable, health history.
- **Information we obtain from others.** This may include claim reports, medical records, credit reports and similar data.
- **Information we obtain through our transactions and experience with you.** This includes your claims history, payment and investment records, and account values.
- **Information we obtain through the Internet.** This includes data from online forms you complete. It also includes data we receive when you visit our websites.

How we share information

We may share personal information about you or about former customers, plan participants or beneficiaries among companies within the Principal Financial Group or with others for several reasons, including:

- to assist us in servicing your account;
- to help design and improve products;
- to protect against potential identity theft or unauthorized transactions;
- in response to a subpoena or for other legal purposes;
- to prevent fraud;
- to comply with inquiries from government agencies or other regulators;
- with others that service your account, or that perform services on our behalf; or
- with your consent, at your request or as allowed by law.

Medical information

We do not share medical information among companies of the Principal Financial Group or with others except:

- when needed to service your policies, accounts, claims or contracts;
- when laws protecting your privacy permit it; or
- when you consent.

Accuracy of information

We strive for accurate records. Please tell us if you receive any incorrect materials from us. We will make the appropriate changes.

Companies within the Principal Financial Group

Several companies within the Principal Financial Group are listed at the top of this Notice. The companies of the Principal Financial Group are leading providers of retirement savings, investment, and insurance products.

More information

You may write to us if you have questions about our Privacy Notice. Contact our Privacy Officer at P.O. Box 14582, Des Moines, Iowa 50306-3582.

To contact us, please call 1-800-986-3343.

Receipt of this notice does not mean your application has been accepted.

We may change our privacy practices at times. We will give you a revised notice when required by law. Our privacy practices comply with all applicable laws.

Your agent, broker, registered representative, consultant or advisor may have a different privacy policy.

Principal℠

PRINCIPAL LIFE INSURANCE COMPANY
DISABILITY INCOME PROTECTION COVERAGE
OUTLINE OF COVERAGE

Insured: _____
Owner(s): _____

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!

It is important to Us that the Owner is satisfied with this policy and that it meets the Owner's insurance goals. If the Owner is not satisfied with this policy for any reason, the policy may be returned by mail or other delivery method to either the producer or Our Home Office within thirty days after the Owner has received the policy. We will refund any premiums paid, plus any policy fee paid, if any, and the policy will be considered void from its inception.

DISABILITY INCOME PROTECTION COVERAGE: Policies of this category are designed to provide, to persons insured, coverage for disabilities resulting from a covered accident or sickness, subject to any limitations set forth in the policy. Coverage is not provided for basic hospital, basic medical-surgical, or major medical expenses.

POLICY BENEFITS

Eligibility to any and all benefits provided by Your policy and attached riders is subject to all definitions, requirements, terms, and conditions expressly stated in the policy and attached riders.

DISABILITY BENEFIT:

Elimination Period _____

Maximum Monthly Benefit (One must be completed.)

☐ Monthly Benefit _____

☐ First _____ of Benefit Period _____

Remainder of Benefit Period _____

☐ First _____ of Benefit Period _____

Next _____ of Benefit Period _____

Remainder of Benefit Period _____

Maximum Benefit Period for the Disability Benefit _____

For Disabilities beginning on or after the Age 61 Policy Anniversary, the Maximum Benefit Period may be adjusted from what is shown above. Refer to the policy Data Page for complete information regarding the Maximum Benefit Period.

YOUR OCCUPATION PERIOD: _____

If this policy is renewed as described in the Conditional Renewal section, the Maximum Benefit Period is 2 years and the Your Occupation Period is 2 years.

SOCIAL INSURANCE SUBSTITUTE BENEFIT (If applicable):

Elimination Period _____

Maximum Monthly Benefit (If applicable, one must be completed.)

☐ Monthly Benefit _____

☐ First _____ of Benefit Period _____

Thereafter _____

DEATH BENEFIT: _____

DISABILITY/DISABLED means, when used alone, Total Disability. If either the Residual Disability Benefit Rider or the Short Term Residual Disability Benefit Rider is attached to Your policy, Disability also means Residual Disability. If a Disability is caused by more than one Injury or Sickness, We will pay benefits as if the Disability was caused by only one Injury or Sickness.

ELIMINATION PERIOD means the number of days of Disability from the start of a Continuous Disability for which no benefits will be paid.

TOTAL DISABILITY – means as a result of Injury or Sickness

1. During the Your Occupation Period You are not able to perform with reasonable continuity the substantial and material acts necessary to perform Your Occupation in the usual and customary way and You choose not to work at any occupation.

2. After the Your Occupation Period You are not able to engage with reasonable continuity in any occupation in which You could reasonably be expected to perform satisfactorily in light of Your age, education, training, experience, station in life, and physical and mental capacity.

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.

If You are Retired, Total Disability means, as a result of Injury or Sickness, You are unable to perform the normal activities of a retired person in good health and of like age. If You are Unemployed, Total Disability means, as a result of Injury or Sickness, You are prevented from obtaining a job that You would reasonably be expected to perform satisfactorily in light of Your age, education, training, experience, station in life, and physical and mental capacity.

YOUR OCCUPATION PERIOD means, beginning with the date of Total Disability, the period of time including the Disability Benefit Elimination Period plus the Your Occupation Period as shown on the Data Page.

IN THIS POLICY THE:

1. Disability Benefit section provides a monthly benefit, after satisfaction of the Elimination Period, during Your Continuous Disability but not beyond the end of the Maximum Benefit Period. For Total Disability, the Maximum Monthly Benefit shown on the Data Page will be paid.

2. Social Insurance Substitute Benefit section provides a monthly benefit, after satisfaction of the Elimination Period, for Your Continuous Disability if amounts for it are shown on the Data Page. To receive this benefit, all requirements of the Social Insurance Substitute Benefit section and all other policy provisions must be met and benefits must be payable under the Disability Benefit section. This section's monthly benefit is:
   a) This section's Maximum Monthly Benefit shown on the Data Page when no Social Insurance is paid; or
   b) One third of this section's Maximum Monthly Benefit shown on the Data Page if the only Social Insurance paid for Your Disability is any one of either the Primary Insurance Amount, Workers Compensation, Railroad Retirement, or any other benefit that replace or supplements Social Security, Workers Compensation or Railroad Retirement.

   No Social Insurance Substitute Benefits will be paid under this section for any period:
   a) You are not receiving benefits under the Disability Benefit section; or
   b) During which two or more of the Social Insurances are paid for Your Disability; or
   c) After Your Age 65 Policy Anniversary, unless Your Maximum Benefit Period is longer and You are receiving benefits under the Disability Benefit section; or
   d) After You are eligible to receive full retirement benefits from Social Security or Railroad Retirement; or
   e) For which You receive retirement benefits from Social Security or Railroad Retirement.

3. Transplant Surgery Benefit pays benefits under the Disability Benefit section and Social Insurance Substitute Benefit section if Your Disability results from surgery involving a transplant of a part of Your body to another person.

4. Death Benefit pays a benefit if You die after satisfying the Elimination Period and while benefits are being paid under the Disability Benefit section or any attached rider.

5. Rehabilitation Benefit will pay the reasonable cost of rehabilitation services, training, and education, not otherwise covered, if You take part in a rehabilitation plan which has been agreed upon in writing and in advance by You, the Owner and Us.

6. Waiver of Premium Benefit waives (or refunds if already paid) premiums after You have been Disabled for the lesser of 90 consecutive days or the Elimination Period. Premiums will continue to be waived as long as Your Disability continues, but not beyond Your Age 65 Policy Anniversary or five years after the Policy Date, whichever is later. For policies issued to individuals age 65 and older, premiums will continue to be waived as long as Your Disability continues, but not beyond the annual Policy Anniversary following Your date of Disability.

POLICY LIMITATIONS

1. This policy does not pay benefits for an Injury or Sickness which is caused by:

   a) Intentional, self-inflicted injury; or
   b) Your commission of or Your attempt to commit a felony, or Your involvement in an illegal occupation; or
   c) Active military service during a military action or conflict; or
   d) Loss We have excluded by name or specific description in any attached rider or endorsement.

2. Benefits will be limited to 12 months during Your Continuous Disability unless You reside in the United States or Canada for at least six consecutive months in each calendar year.

3. Normal pregnancy or normal childbirth are not covered Sicknesses unless Your policy contains an Elimination Period of 90 days or more.

4. No benefits are provided for Disability caused by Sickness which first manifests itself or Injury which occurs prior to the Policy Date.

5. We have the right to void the coverage(s) due to a material misstatement in the application during the first two years from the effective date of coverage(s). After two years from the effective date of coverage(s) only fraudulent statements made by You or the Owner in an application will be used to void the coverage(s).

6. Your policy will be suspended while You are on full-time active duty in the military service of any nation or international authority. We will refund the pro rata portion of any premium paid for a period 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 180 days following the date active duty ends, Your policy may be restored. The restored policy will only cover Disabilities from a Sickness or an Injury which occurs after the policy is restored.

PRE-EXISTING CONDITION LIMITATION

You are not covered for a Disability caused or substantially contributed to by a Pre-Existing Condition or medical or surgical treatment of a Pre-Existing Condition. You have a Pre-Existing Condition if:

1. You received medical treatment, care or services for a diagnosed condition or took prescribed medication for a diagnosed condition in the 24 months immediately prior to the effective date of coverage(s) under this policy, or

2. You suffered from a physical or mental condition, whether diagnosed or undiagnosed, which was misrepresented or not disclosed in Your application(s) for which You received a Doctor's advice or treatment within 2 years before the effective date of coverage(s), or which caused symptoms within 1 year before the effective date of coverage(s) for which a prudent person would usually seek medical advice or treatment, and

3. The Disability caused or substantially contributed to by the condition begins in the first 24 months after the effective date of coverage(s) under this policy.

RIDER INFORMATION (As applicable)

☐ ADDITIONAL EXCEPTION/MODIFIED COVERAGE/EXCLUSION RIDERS. These riders exclude or modify coverage for certain conditions or for Injury or Sickness caused by certain circumstances or occurring in specified geographic locations. See the rider attached to the policy.

☐ BENEFIT UPDATE RIDER. This rider offers to increase Your Disability Benefit and any Social Insurance Substitute Benefit every three years to the maximum We would issue according to Your then current situation and Our rules. The rider also allows You to elect to have the Disability Benefit and any Social Insurance Substitute Benefit reviewed instead of the next regularly scheduled review if You lose group long term disability insurance (or it is reduced) subject to the requirements specified in the rider, or You have had at least a 50% increase in Your Earnings since the last adjustment. You need not show evidence of good health. No further offers will be made when You reach Your Age 55 Option Anniversary, except one regularly scheduled review will be made for any rider issued on or after age 52.

☐ CAPITAL SUM BENEFIT RIDER. This rider pays an additional one-time benefit, subject to the rider provisions, if an Injury or Sickness results in Your total loss of use for any and every purpose or activity without any possibility of recovery of: a) The use of a hand or foot; or b) The sight of an eye.

Capital Sum Benefit: $ _____

☐ CATASTROPHIC DISABILITY BENEFIT RIDER. This rider provides a monthly Catastrophic Disability Benefit during Your Continuous Catastrophic Disability after satisfaction of the Catastrophic Disability Elimination Period. The Catastrophic Disability Elimination Period is waived for Presumptive Disability. The Catastrophic Disability Maximum Benefit Period is the longest period of time the Catastrophic Disability Benefit will be paid.

Catastrophic Disability Benefit: _____
Catastrophic Disability Elimination Period: _____
Catastrophic Disability Maximum Benefit Period: _____

For Catastrophic Disabilities beginning on or after the Age 61 Policy Anniversary, the Catastrophic Disability Maximum Benefit Period may be adjusted from what is shown above. Refer to the policy Data Page for complete information regarding the Catastrophic Disability Maximum Benefit Period.

☐ CONDITIONALLY RENEWABLE POLICY RIDER. This rider is attached to policies issued to individuals age 65 and over on date of application. The rider changes the policy to a conditionally renewable policy.

☐ COST OF LIVING ADJUSTMENT RIDER. This rider provides that, each year on the Change Date, We will adjust Your Maximum Monthly Benefits which were in effect at the start of Your Continuous Disability to new amounts. Monthly benefits will be calculated by multiplying the Maximum Monthly Benefits by a COLA Index Factor. Then these adjusted maximum monthly benefits are used to calculate Your new monthly benefit amount. The COLA Index Factor is based on the change in the Consumer Price Index for All Urban Consumers (CPI-U) on an annual basis subject to the limits specified in the rider.

☐ FUTURE BENEFIT INCREASE RIDER. This rider offers to increase Your Total Monthly Benefit on each Option Anniversary during a Term, subject to the Limitations and Conditions provision of the rider. The increase is based on the Consumer Price Index for All Urban Consumers (CPI-U) as published by the United States Department of Labor. On each Option Anniversary you may also apply for an additional benefit up to a maximum of $500.00 (which includes the automatic increase). If you are eligible based on our current underwriting guidelines, You need not show evidence of good health. This rider may be renewed on every sixth Option Anniversary for another Term. We will require an application and other evidence which satisfies that You are insurable under Our then current underwriting guidelines except that You need not show evidence of good health. No further offers will be made when You reach Your Age 55 Option Anniversary or the end of the first Term, whichever is later.

☐ LIMITATION OF BENEFITS FOR MENTAL/NERVOUS/SUBSTANCE ABUSE DISORDERS. This rider limits monthly benefits paid for such disorders to an aggregate total of 24 months during the life of the policy. However, subject to the Maximum Benefit Period and all other policy provisions, Monthly Benefits will be paid as long as You are continuously confined as an inpatient in a Hospital.

☐ PRESUMPTIVE DISABILITY BENEFIT RIDER. This rider pays for Total Disability under the Disability Benefit section and Social Insurance Substitute Benefit section of the policy, regardless of the ability to Work or earn an income, if an Injury or Sickness results in Your total loss for any and every purpose or activity without any possibility of recovery of:

a) Power of speech; or
b) Hearing in both ears; or
c) Sight of both eyes; or
d) The use of both hands, both feet, or one hand and one foot.

The Presumptive Disability must occur while the policy and this rider is in force and prior to the Age 65 Policy Anniversary or five years from the Policy Date, whichever is later. Monthly benefits will be paid as long as the Presumptive Disability continues, but no longer than the benefit period described in Your policy.

☐ RECOVERY BENEFIT RIDER. This rider pays benefits after You are no longer Disabled but You continue to have a Loss of Earnings of at least 20% due to Your prior Disability.

☐ REGULAR OCCUPATION RIDER. This rider pays the benefits under the policy if You meet this rider's definition of Total Disability during the Your Occupation Period.

☐ RESIDUAL DISABILITY BENEFIT RIDER. This rider provides a portion of the Maximum Monthly Benefit if You are not Totally Disabled and that while actually working in an occupation, as a result of Injury or Sickness, You are unable to earn 80% or more of Your Prior Earnings. The Maximum Benefit Period for these benefits is the same as provided by the policy for the Disability Benefit.

☐ SHORT TERM RESIDUAL DISABILITY BENEFIT RIDER. This rider provides a portion of the Maximum Monthly Benefit if You are not Totally Disabled and that while actually working in an occupation, as a result of Injury or Sickness, You are unable to earn 80% or more of Your Prior Earnings. Benefits provided by this rider are payable to the end of the Short Term Residual Disability Benefit Period shown on the Data Page but not beyond the Maximum Benefit Period.

☐ TRANSITIONAL OCCUPATION RIDER. This rider pays benefits if You work in another occupation and You are Totally Disabled from Your Occupation during the Transitional Occupation Period.

The monthly benefit will be equal to the lesser of:

1. Prior Earnings MINUS Current Earnings MINUS Other Disability Coverage; or
2. The Maximum Monthly Benefit PLUS any Social Insurance Substitute Benefit.

RENEWAL AND OTHER INFORMATION

FOR INDIVIDUALS AGE 64 AND UNDER ON DATE OF APPLICATION: The policy is non-cancellable and guaranteed renewable at guaranteed premium rates to Your Age 65 Policy Anniversary or for five years from the Policy Date, whichever is later. The policy, except the Social Insurance Substitute Benefit and certain attached riders, is conditionally renewable thereafter on an annual basis for life, subject to change in premium rates. The Social Insurance Substitute Benefit, if included, is continuable at guaranteed premium rates to the earlier of Your Age 65 Policy Anniversary or upon receipt of Social Security retirement benefits or Railroad Retirement benefits.

FOR INDIVIDUALS AGE 65 AND OVER ON DATE OF APPLICATION: This policy is conditionally renewable on an annual basis for life, subject to change in premium rates.

PREMIUM INFORMATION

Total Annual Premium: _____

Premium Payment Frequency Option Selected: _____

Premium Payable*: _____

*There is an additional charge for premium payment frequencies other than annual. Please refer to an illustration or the policy Data Pages for details.

FOR INDIVIDUALS AGE 64 AND UNDER ON DATE OF APPLICATION: Premiums are guaranteed to Your Age 65 Policy Anniversary or for five years from the Policy Date, whichever is later. Thereafter, if the policy is renewed under the Conditional Renewal section, premiums will be those in effect at that time.

FOR INDIVIDUALS AGE 65 AND OVER ON DATE OF APPLICATION: Premiums are guaranteed to the next renewal date.

A grace period of 31 days is allowed after the premium due date to pay the premium due.

THE LOSS RATIO FOR THE PRECEDING CALENDAR YEAR WAS 53%.

Date: _____

Chairman, President and CEO

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 —

DISCLOSURE – Give to Proposed Insured

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

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.

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