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

Proposed Insured _____

D.O.B. ____ / ____ / _____ Policy Number (If known) _____

PART B

All references to "you" mean the Proposed Insured.

ACTIVITIES/HEALTH HABITS

1. In the last five years have you, or do you have plans to:
   a. be a member of any armed forces or military unit? ☐ Yes ☐ No
   b. pilot any type of aircraft? ☐ Yes ☐ No
   c. engage in scuba/skin diving, motor vehicle racing, skydiving or any other hazardous sporting activity? ☐ Yes ☐ No
   d. live outside the United States or Canada? (If yes, explain below) ☐ Yes ☐ No
   e. travel outside the United States or Canada? (If yes, explain below) ☐ Yes ☐ No
2. In the last five years have you:
   a. been in a motor vehicle accident, been convicted of driving while intoxicated or had more than one moving violation? (If yes, explain below) ☐ Yes ☐ No
   b. been on parole or probation or convicted of a felony or misdemeanor? (If yes, explain below) ☐ Yes ☐ No
3. In the last ten years have you used any tobacco or nicotine products? ☐ Yes ☐ No
   (Indicate date last used and amount per day)
   a. ☐ cigarettes _____ d. ☐ pipe _____
   b. ☐ cigars _____ e. ☐ chewing tobacco/snuff _____
   c. ☐ nicotine patch/gum _____ f. ☐ other _____
4. In the last ten years have you consumed alcoholic beverages? ☐ Yes ☐ No
   If yes, date last used? _____ Number of drinks per week: _____
5. In the last ten years have you used cocaine, marijuana, methamphetamines, barbiturates or other controlled substances? ☐ Yes ☐ No
6. Have you ever been advised to limit or discontinue the use of alcohol or drugs; or sought or received treatment because of your alcohol or drug use? ☐ Yes ☐ No

DETAILS TO QUESTIONS 1-6

Quest. #	Include dates and details as requested above.

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

Proposed Insured _____

D.O.B. ____ / ____ / _____ Policy Number (If known) _____

PART B – (Continued)

INCOME/OCCUPATION

For Life, complete questions 7 and 8. For DI, complete questions 8-17. In all cases, Part B continues on the next page.

7. Annual income from occupation $ _____ Other Income $ _____
   Source of other income _____ Net Worth (Assets – Liabilities) $ _____
8. Primary occupation _____ Employer _____
9. Current Employment Information
   a. Type of business or industry _____
   b. Job title _____
   c. What are your job activities and percentage of time spent in each? _____
   d. How many hours do you usually work per week in your primary job? _____
   e. Total number of employees: Full-time _____ Part-time _____ Sub-contracted _____
   f. How many employees do you supervise? _____
10. How long have you been employed by your current employer? _____ (If less than three years, provide details below, e.g., employers, occupations and dates for last five years.)
11. Do you work out of your home? (If yes, how many hours per week? _____) ☐ Yes ☐ No
12. Do you have any other part-time or full-time jobs? (If yes, explain below) ..... ☐ Yes ☐ No
13. Are you actively at work on a full-time basis without medical restriction? (If no, explain below) ..... ☐ Yes ☐ No
14. Do you intend to change jobs or employment in the next 6 months? (If yes, explain below) ..... ☐ Yes ☐ No
15. Have you ever requested or received any type of disability benefits (including workers' compensation and state disability) for an injury or illness? (If yes, explain below)..... ☐ Yes ☐ No
16. Do you have an ownership interest in any business you work for? ..... ☐ Yes ☐ No
    If yes, ownership percentage _____ length of ownership _____
    Type of business: ☐ C Corporation ☐ S Corporation ☐ Partnership
    ☐ Sole Proprietorship ☐ Limited Liability Company ☐ Other _____
17. Have you, or any business owned in whole or part by you, ever been in bankruptcy or any similar proceedings? (If yes, provide date discharged, type and chapter)..... ☐ Yes ☐ No

DETAILS TO QUESTIONS 7-17

Quest. #	Include dates and details as requested above.

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

Proposed Insured _____

D.O.B. ____ / ____ / _____ Policy Number (If known) _____

PART B – (Continued)

MEDICAL HISTORY (Provide details to yes answers, questions 18-20 below)

18. In the last ten years, have you had, been treated for or been diagnosed as having:
    a. high blood pressure, heart attack, chest pain, heart murmur, irregular heart beat, stroke, or any other disease or disorder of the heart or blood vessels? ☐ Yes ☐ No
    b. cancer or a tumor, cyst or growth? ☐ Yes ☐ No
    c. asthma, bronchitis, emphysema, tuberculosis or any other disease or disorder of the lungs or respiratory system? ☐ Yes ☐ No
    d. seizure, paralysis, headaches, multiple sclerosis or any other disease or disorder of the brain or nervous system? ☐ Yes ☐ No
    e. chronic fatigue, stress, depression, anxiety or any other emotional or psychological disorder? ☐ Yes ☐ No
    f. hepatitis, colitis, ulcer, cirrhosis, irritable bowel or any other disease or disorder of the liver, gallbladder, pancreas or digestive tract? ☐ Yes ☐ No
    g. diabetes, borderline diabetes, sugar in the urine, thyroid disorder or any other disease or disorder of the glandular system? ☐ Yes ☐ No
    h. kidney stones, nephritis, any blood or protein in the urine, sexually transmitted disease, prostate disorder, breast disorder or any other disease or disorder of the urinary or reproductive system? ☐ Yes ☐ No
    i. back or neck pain, disc problems, spinal sprain or strain, sciatica, arthritis, carpal tunnel syndrome, or any other disease or disorder of the bones, joints, or muscles? ☐ Yes ☐ No
    j. any disease or disorder of the eyes, ears, nose, throat or skin? ☐ Yes ☐ No
19. (DI Only) Are you currently pregnant or have you had complications of pregnancy in the last ten years? ☐ Yes ☐ No
20. In the last ten years, have you had, been treated for or been diagnosed as having HIV (Human Immunodeficiency Virus) infection or AIDS (Acquired Immunodeficiency Syndrome)? ☐ Yes ☐ No

DETAILS TO QUESTIONS 18-20

Quest. #	For yes answers, include dates, details, diagnosis, types and results of treatment, healthcare provider's full name and address.

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

Proposed Insured _____

D.O.B. ____ / ____ / _____ Policy Number (If known) _____

PART B – (Continued)

MEDICAL HISTORY

21. Who is your Primary Physician? ☐ None
    a. Name Phone Number

    Street City State Zip

    b. Date last seen, reason and details

22. In the last ten years:
    a. have you had any medical tests, hospitalization, illness or injury not provided in response to a previous question? (If yes, explain below) ..... ☐ Yes ☐ No
    b. have you consulted a doctor, chiropractor, psychiatrist, psychologist, counselor, therapist or other healthcare provider not provided in response to a previous question? (If yes, explain below) ..... ☐ Yes ☐ No
23. Are you taking or have you been advised to take any medication or treatment not provided in response to a previous question? (If yes, explain below) ..... ☐ Yes ☐ No
24. Current Ht. _____ Wt. _____ Have you lost more than 10 lbs. in the last year? ..... ☐ Yes ☐ No
    If yes, _____ lbs./kgs. Indicate reason _____
25. a. Has either of your natural parents lived to at least age 60? (If no, explain below)..... ☐ Yes ☐ No
    b. Do any of your natural parents or siblings have a history of diabetes, cancer, stroke or heart disease? ..... ☐ Yes ☐ No
    If yes, provide details (i.e., relationship, type of disease, age diagnosed, current age or age at death):
26. Have you ever had any life, health or disability insurance rated, ridered or declined? (If yes, explain below)..... ☐ Yes ☐ No

DETAILS TO QUESTIONS 21-26

Quest. #	Include dates and details as requested above.

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

Individual Disability Insurance Application

Thank you for choosing Principal Life Insurance Company to meet your client's individual disability insurance needs.

Please follow the instructions below to expedite the application process.

General Instructions

☐ Complete **Part A** of the application and obtain signatures on **Part C.** Answer all questions legibly in blue or black ink. The **applicant** is required to initial any changes.

☐ Complete the **Producer Report** and all **supplemental forms** (if applicable).

☐ If utilizing the TeleApp process, please call toll free **1-888-835-3277** (1-888-TELEAPP) to schedule the telephone application interview. A TeleApp counselor will ask the questions from Part B (medical/habits information) of the application.

If using the traditional application process, obtain and complete **PART B** of the application. Answer all questions legibly in blue or black ink. The **applicant** is required to initial any changes. A personal telephone interview (PTI) is also required when using the traditional application process. To schedule the PTI call 1-888-835-3277.

NOTE: The TeleApp Counselor will offer to order Routine Underwriting Requirements for all new applications.

☐ **Association Sales Program applications** require home office pre-approval and a copy of the Association Endorsement letter. If you have an Association, whose members you market disability insurance products to, please contact Jeff Hannemann at 1-800-247-9988, x20992 or Hannemann.Jeff@principal.com for pre-approval.

☐ Submit the **Producer Report**, **Part A, Part B** (if applicable), **Part C and all supplemental forms** (if applicable). Please do not duplex the application pages and only print data and wording on one side of a page.

☐ Submit **verification of income/financial** documentation (if applicable). For Business Loan Protection Rider, submit a copy of the loan agreement.

☐ Submit the **Premium Summary Report** of the DI Illustration. Submitting this report helps expedite the underwriting process.

☐ If COD (Cash on Delivery) do not give the **Conditional Receipt** to the applicant/proposed insured. If money is taken with the application or if the pre-approved Payroll Deduction Form (Applicable to Multi-Life cases only) is used, then give the Conditional Receipt to the applicant/Proposed Insured.

☐ If multiple producers are indicated on the Producer Report (question 3, page 1) the **1st year and renewal commissions**, including contractual benefit increases such as FBI and BU, are paid per the split indicated. The producer listed on the 1st line in the box indicating **Servicing Producer,** is designated to provide policy service and receive all applicable service correspondence sent to the client. To change the **recipient of commissions** for new adjusted coverage and subsequent contractual increases such as FBI and BU, an **Agent of Record Change** is required and should be submitted to Marketer Services.

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

Individual Disability Insurance Producer Report

Proposed Insured _____ Policy Number _____

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

Contact Name	Contact's Phone Number	Contact's Email Address
Jane Nobiletti	**(212) 697-2025 x309**	**jane@asglife.com**

2. Producer Information

Producer's Office Name	Producer's Principal Office Number	Producer's Phone Number
Agent Support Services, Inc.	**1066**	**(212) 697-2025 x309**

3. Compensation Information

List all Producers to Receive Compensation	Tax ID Number	Statement/ Detail Code	Commission Split % must equal 100
Servicing Producer (receives correspondence)			
Enter Signing Producer's Tax ID Number for Corporation or Non-Corporation			

4. Underwriting Requirements (Please check the underwriting requirements that have been ordered)

☐ TeleApp/Personal Telephone Interview (PTI) Confirmation Number _____

If TeleApp or PTI has not been scheduled, please call 1-888-TeleApp and schedule at this time.

Is an interpreter required for TeleApp? ☐ Yes ☐ No If Yes, list language: _____

☐ HOBP/HOS Ordered through _____

☐ Urine-HIV Ordered through _____

☐ Mini/Paramed Ordered through _____

☐ EKG Ordered through _____

☐ APS _____ ☐ Other _____

5. Additional Information

a. <u>Discounts</u> (check those that apply)

☐ Multi-Life (List Bill – requires three or more lives)

Employer's Name _____

Employer's Address _____

_____

Employer Tax ID _____

List Bill Number (if known) _____

Initial Billing sent to ☐ Producer ☐ Employer

☐ Association (If approved in your state)

Association Name _____

Association Number _____

☐ Mental/Nervous (Not available in Texas)

☐ Select Occupation

b. Occupation Class Quoted: ☐ 5A ☐ 5A-M ☐ 4A ☐ 4A-M ☐ 3A ☐ 3A-M ☐ 2A ☐ A

c. Send premium notices to (if other than the policyowner) _____

_____

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

Please Submit with Application

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

Individual Disability Insurance Producer Report

Proposed Insured _____ Policy Number _____

5. Additional Information (Continued)

e. Is English the Proposed Insured's primary language?..... ☐ Yes ☐ No
(If No, submit the **Statement of English Understanding** form)

f. If special dating is essential, indicate policy date desired: ___/___/___ . If money is taken with application, requests for advance dating will not be honored except to conform with established Electronic Funds Transfer date.

g. Are funds being submitted with the application? ☐ Yes ☐ No; If Yes, what is the amount? $ _____

h.

Product	Payment Mode	Mode Premium	Total Annual Premium

i. Comments or special instructions _____

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

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

Please Submit with Application

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)
☐ **Key Person Replacement** (Complete Sections 4-7, Part C, and the *Key Person* Application Supplement)

3. Disability Income

Monthly Benefit Amount: $ _____
Elimination Period: ☐ 30 day ☐ 60 day ☐ 90 day ☐ 180 day ☐ 365 day
Benefit Period: ☐ 2 year ☐ 5 year ☐ to age 65 ☐ to age 67 ☐ to age 70
Your Occupation Period: ☐ 2 year ☐ 5 year ☐ to age 65 ☐ to age 67 ☐ to age 70
SIS Monthly Benefit: $ _____ SIS Benefit Period must equal Base Benefit Period.
SIS Elimination Period: ☐ 30 day ☐ 60 day ☐ 90 day ☐ 180 day ☐ 365 day
Adaptable Income Benefits (AIB) **Note: 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

☐ Cost of Living Adjustment: ☐ 3% max ☐ 6% max
☐ Extended Total Disability Benefit
Aggregate Benefit Factor: ☐ 50 ☐ 75 ☐ 100
☐ 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 _____

Benefit Recipient (if other than Owner) for Disability Income Only

Name _____ Address _____

City _____ State _____ Zip _____

4. Premium Payer and Method of Payment

a. Premium paid by: ☐ 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 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, Credit Insurance plans, or Loan Protection coverage.

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 Financial Group

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 belief 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/$ _____ for Key Person Replacement 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, or any other organization, institution, or person 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 earlier of: (1) the date of this application(s), or (2) the date of my policy. I may revoke this authorization for information not then obtained. Such revocation must be in writing. It will not be effective until received at the Company's Home Office. I agree that a photocopy of this authorization is as valid as the original. I have received a copy of this authorization.

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

SIGNATURES (Please do not print name below. **Signatures, City, State and Date are required.**)

Proposed Insured **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 / /
Key Person Replacement; Owner **X**	Title (Officer other than Proposed Insured)		Date / /
Agent/Broker/Licensed Representative **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 belief 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/$ _____ for Key Person Replacement 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, or any other organization, institution, or person 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 earlier of: (1) the date of this application(s), or (2) the date of my policy. I may revoke this authorization for information not then obtained. Such revocation must be in writing. It will not be effective until received at the Company's Home Office. I agree that a photocopy of this authorization is as valid as the original. I have received a copy of this authorization.

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

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) $ _____ (Key Person) $ _____

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, Overhead Expense, Business Loan Protection Benefit, Disability Buy-Out or Key Person Replacement –** 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, Overhead Expense, Business Loan Protection Benefit, Disability Buy-Out or Key Person 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); $5,000 per month (Business Loan Protection Benefit); $2,500 per month and $200,000 Lump Sum (Key Person Replacement 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.

Compensation includes payments, commissions, fees, awards, overrides, bonuses, contingent commissions, loans, stock options, gifts, prizes or any other form of valuable consideration, whether or not payable pursuant to a written agreement. 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).*

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).*

Principal Life Insurance Company
Principal National Life Insurance Company
Members of Principal Financial Group®
P.O. Box 10431, Des Moines, IA 50306-0431

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

Authorization for Withdrawals and/or Electronic Fund Transfers by the Principal Financial Group®

This Space for Agency and Home Office Use Only

Agency Number | Unit Number | Representative | Date MM/DD/YYYY

Attn | From

Instructions

1. Complete the section below – please print or type.
2. Sign and date this authorization form.
3. Be sure to attach an unsigned, Void Check so we may duplicate the magnetic coding.
4. Any initial insurance or annuity premium check should be payable to Principal National Life Insurance Company or Principal Life Insurance Company.

Terms and Conditions

1. Withdrawals or electronic fund transfers for existing insurance policy or annuity contract premiums will be made without regard to any insurance policy or annuity contract applications that may be pending with this company. When any insurance policies or annuity contracts are issued, the amount of the withdrawals or electronic fund transfers will be increased sufficiently to include the premium or the new policy contract.
2. Withdrawals or electronic fund transfers will be made on or around the day of the month that the earliest payment (any one mutual fund, policy or contract) is due, unless another date is requested below.
3. While premiums are paid under this plan, premium notices will not be mailed nor will the Automatic Premium Loan privilege be available. Any cancelled instruments will constitute receipts for payment of premiums. Transaction confirmations will be prepared and sent as required by law and regulation.

Type of Request (Please check where applicable)

☐ First Request ☐ Change of Institutions or Accounts ☐ Add to Present Plan No. _____

☐ Flex Draw Date to (Not available on certain Life products) _____

(Types of Account) ☐ Checking ☐ Savings

Authorization for Withdrawals and/or Electronic Fund Transfers

This authorization applies to the attached application (if any) dated Date MM/DD/YYYY and/or the following:

Account/Policy Contract Number

Monthly Amount (if applicable)

$ | $ | $ | $ | $

I authorize Principal National Life Insurance Company and/or Principal Life Insurance Company (hereafter referred to as "Companies") to debit my account as needed to pay premiums.

Name of Financial Institution | Phone ( )

Address | City | State | ZIP

Account Holder's Name | Transit and Routing No. | Account No.

Joint Account Holder's Name

I authorize the financial institution named above to honor withdrawals and/or electronic fund transfers by the Companies listed above. I understand if any withdrawals or electronic fund transfers are dishonored by you, whether with or without cause, that you shall be under no liability.

This authorization will remain in effect until cancelled either by myself, the Companies, or the financial institution named above. Notification of such cancellation must be given within 10 working days of the transaction by the party canceling the authorization.

X _____ _____ _____ _____

Signature of Account Holder | City | State | Date MM/DD/YYYY

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

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

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

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

Insurer Name	Address
Examiner Name	**Address**

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

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

Unless precluded by law, tests will be performed to determine the presence of HIV antibodies or antigens. The HIV antibody test that we perform is actually a series of tests done by a medically accepted procedure. The HIV antigen test directly identifies AIDS viral particles. These tests are extremely reliable. Should you desire more information about the test of HIV infection before providing a blood sample, you may wish to consult with your physician or your local health department. If you are at high risk of HIV infection, you may want to be counseled and tested by your physician or at a free/low cost local test site. Your local health department can provide you with information as to the location of these sites.

All test results will be treated confidentially. They will be reported by the laboratory to the insurer. When necessary for business reasons in connection with insurance you have or have applied for with the Insurer, the Insurer may disclose test results to others such as its affiliates, reinsurers, employees or contractors, but not to agents and brokers.

If the Insurer is a member of the Medical Information Bureau (MIB, Inc.), and if the test results for HIV antibodies/antigens are other than normal, the Insurer will report to the MIB, Inc. a generic code which signifies only a non-specific blood test abnormality. If your HIV test is normal, no report will be make about it to the MIB, Inc.

The organizations described in the last two paragraphs may maintain the test results in a file or data bank. There will be no other disclosure of test results or even that the tests have been done except as may be required or permitted by law or as authorized by you.

If your HIV antibody/antigen test results do not mean that you have AIDS, but that you are a significantly increased risk of developing AIDS or AIDS-related conditions. Federal authorities say that persons who are HIV antibody/antigen positive should be considered infected with the AIDS virus and capable of infecting others.

Positive HIV antibody or antigen test results or other significant blood abnormalities will adversely affect your application for insurance. This means that your application may be declined, that an increased premium may be charged, or that other policy changes may be necessary.

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

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

Name

Address	City	State	ZIP

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

I understand that I have the right to request and receive a copy of this authorization. A photocopy of this form will be as valid as the original.

X _____ **X** _____

Signature of Proposed Insured or Parent/Guardian — Date MM/DD/YYYY

Print Name — Date of Birth MM/DD/YYYY

State of Residence

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

Principal Life Insurance Company
Principal National Life Insurance Company
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P.O. Box 10431
Des Moines, IA 50306-0431

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

Unless precluded by law, tests will be performed to determine the presence of HIV antibodies or antigens. The HIV antibody test that we perform is actually a series of tests done by a medically accepted procedure. The HIV antigen test directly identifies AIDS viral particles. These tests are extremely reliable. Should you desire more information about the test of HIV infection before providing a blood sample, you may wish to consult with your physician or your local health department. If you are at high risk of HIV infection, you may want to be counseled and tested by your physician or at a free/low cost local test site. Your local health department can provide you with information as to the location of these sites.

All test results will be treated confidentially. They will be reported by the laboratory to the insurer. When necessary for business reasons in connection with insurance you have or have applied for with the Insurer, the Insurer may disclose test results to others such as its affiliates, reinsurers, employees or contractors, but not to agents and brokers.

If the Insurer is a member of the Medical Information Bureau (MIB, Inc.), and if the test results for HIV antibodies/antigens are other than normal, the Insurer will report to the MIB, Inc. a generic code which signifies only a non-specific blood test abnormality. If your HIV test is normal, no report will be make about it to the MIB, Inc.

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I understand that I have the right to request and receive a copy of this authorization. A photocopy of this form will be as valid as the original.

X _____ **X** _____

Signature of Proposed Insured or Parent/Guardian — Date MM/DD/YYYY

Print Name — Date of Birth MM/DD/YYYY

State of Residence

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

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. We may also provide data to: (1) MIB, Inc.; (2) other insurance companies, if you authorize release of the data to them; (3) our reinsurers, if needed to secure reinsurance; (4) federal and state agencies, and others if required by law; (5) our research personnel (anonymously) to help market our products.

Access To Your Data
Upon your written request, we will provide you with the nature and scope of your personal data in our records. You must give us proper identification. We will respond to your request within 21 days from the date of receipt. You may be charged a fee for any copies of your data. You have the right to receive in writing the specific information leading to an adverse underwriting 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. You have the right to see your nonmedical data and obtain a copy. You have the right to correct or amend any data in your file. Any request for correction or amendment must be in writing. If we agree with you, we will notify anyone we may have given such incorrect data. We will also delete data from your file if we agree it is incorrect. If we disagree with your correction or amendment, we will give you our reason. You may respond in writing listing the basis on which you dispute the correctness of the data. Your response will be added to your file.

Information obtained through consumer reporting agencies will be furnished to you according to the provisions of the Fair Credit Reporting Act. You have a right to see and obtain a copy of any report made.

Upon written request, we will tell you the name of any person to whom we may have given your data. You should direct all requests to: Disability Insurance Underwriting Officer, P.O. Box 14455, Principal Life Insurance Company, Des Moines, Iowa 50306-3455 (Telephone 1-800-247-9988, extension 83797).

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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