Principal®

☐ **Principal Life Insurance Company**
☒ **Principal National Life Insurance Company**
Members of Principal Financial Group®

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

Individual Life Insurance Application

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

PART A

1. PERSONAL INFORMATION ABOUT THE PROPOSED INSURED

Name (First, Middle, Last)	Sex ☐ Male ☐ Female	Date of Birth / /
Primary Residence Street Address	Social Security Number - -	Birthplace (State, or Country if not U.S.)
City, State, Zip Code	Driver's License Number	State Issued
Phone Number ☐ Cell ☐ Other ( )	Occupation	
Email Address	Workplace Zip Code	

2. BASIC COVERAGE APPLIED FOR

Product _____ Policy Planned Premium $ _____

Face Amount (excluding riders)
$ _____

Premium Frequency: (choose one)
☐ Annual ☐ Semi Annual ☐ Quarterly ☐ Single Pay
☐ EFT (complete EFT form + attach sample check)

Death Benefit Option if applicable:
☐ Option 1: Level Face Amount
☐ Option 2: Face + Accumulated/Policy Value
☐ Option 3: Face + Premiums Paid Less Partial Surrenders

List Bill Number _____
☐ Annual ☐ Semi Annual ☐ Quarterly ☐ Monthly
Unscheduled Premium $ _____

Payor: Is someone other than the Proposed Insured or Owner going to be paying the premiums?
If yes, please provide:
Name and Address _____
Date of Birth _____ Tax ID Number _____

3. BENEFITS/RIDERS (Some riders are not available with all products)

☐ Business Value Increase
☐ Children Term – Amount $ _____
☐ Conversion Extension
☐ Extended No Lapse Guarantee
☐ Four Year Term
☐ Salary Increase – Amount $ _____
☐ Supplemental Benefit
☐ Surrender Value Enhancement
☐ Waiver of Premium/Specified Premium
☐ Waiver of Monthly Deductions/Monthly Policy Charges
☐ _____
☐ _____

4. BENEFICIARY INFORMATION. The requested personal information will help the Company locate your beneficiary(ies) at the time of a death claim.

Primary Beneficiary	SSN/TIN	Relationship to Proposed Insured
Address *(Street, City, State, Zip)*		
Primary Beneficiary	SSN/TIN	Relationship to Proposed Insured
Address *(Street, City, State, Zip)*		
Contingent Beneficiary	SSN/TIN	Relationship to Proposed Insured
Address *(Street, City, State, Zip)*		
Contingent Beneficiary	SSN/TIN	Relationship to Proposed Insured
Address *(Street, City, State, Zip)*		

Proposed Insured Name _____

5. OWNERSHIP INFORMATION

Owner Name (If trust, provide name of trust*)	Relationship to Proposed Insured
Primary Residence Street Address	Taxpayer Identification Number
City, State, Zip Code	Date of Birth (If trust, provide date of trust*)
Email Address	

Joint Owner Name	Relationship to Proposed Insured
Primary Residence Street Address	Taxpayer Identification Number
City, State, Zip Code	Date of Birth
Email Address	

Contingent Owner Name	Relationship to Proposed Insured

*** Submit copy of trust with this application.**

6. CHANGE OF OWNERSHIP

(a) Is there an intention that any group of investors will obtain any right, title, or interest in any policy issued on the life of the Proposed Insured(s) as a result of this application? ..... ☐ Yes ☐ No
If yes, explain. _____

(b) Will you borrow money to pay the premiums for this policy or have someone else pay these premiums for you in return for an assignment of policy values back to them? ..... ☐ Yes ☐ No
If yes, explain and complete premium financing acknowledgment form. _____

7. OTHER INSURANCE

(a) Is there other life insurance or annuities in force or applied for? ..... ☐ Yes ☐ No
(If yes, list all other life insurance or annuities in force or currently being applied for, even if sold, assigned, or viaticated.)

Insured's Name	Company	Amount	Policy Number	Check if Pending	Year Issued	Primary Purpose
		$		☐		
		$		☐		
		$		☐		
		$		☐		

(b) If coverage is pending, will all pending coverage be accepted? ..... ☐ Yes ☐ No
If no, explain. _____

(c) Have you transferred or assigned any right, title, or interest in any life insurance or annuity contract other than absolute assignment for Internal Revenue Code 1035 exchange? ..... ☐ Yes ☐ No
If yes, explain. _____

8. REPLACEMENT

(a) Will the insurance applied for with this application replace or affect any of the owner's other life or annuity contracts (including pending coverage provided with a binding receipt)? ..... ☐ Yes ☐ No
If yes, list company name(s) and policy number(s) and provide necessary forms:

_____

_____

(b) Is this an Internal Revenue Code section 1035 exchange? ..... ☐ Yes ☐ No

Proposed Insured Name _____

9. MEDICAL QUESTION

Within the last ten years, has the Proposed Insured been treated for or been diagnosed by a member of the medical profession as having a heart condition, chest pain, stroke, cancer, diabetes, alcohol abuse or drug dependency? ☐ Yes ☐ No

(If yes, explain below.)

Details (including dates and healthcare provider's name/address)

(Continue to next page)

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

PART C – AGREEMENT/AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

AGREEMENT

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

I understand that the policy(ies) delivered to me may be from a different issuer than what was listed in the application. I understand and agree that my acceptance of the policy(ies) shall be considered an amendment to this application. Each policy has only one issuing company (Principal Life Insurance Company or Principal National Life Insurance Company) and that issuer is solely responsible for the obligations under that policy.

When Policy Coverage Becomes Effective: I understand and agree that if a policy is issued as applied for with a premium deposit paid, policy coverage will become effective as of issuance. The Company agrees to pay any proceeds pursuant to policy terms subject to the acceptance of the proposed owner and signing of Part D, if applicable.

I understand and agree that if a policy is issued as other than applied for or without a premium deposit (C.O.D.), then policy coverage is not effective and the Company shall incur no policy liability unless:

1) A policy issued on this application has been physically delivered to and accepted by the owner and the first premium paid; and
2) At the time of such delivery and payment, to the best of the Insured's and my belief, the person to be insured is actually in the state of health and insurability represented in this application, medical questionnaire, or amendment that becomes a part of this application; and
3) The Part D or the Acknowledgment of Delivery form is signed by me and the Proposed Insured (if different than me) and dated at delivery.

If these conditions are met, the policy is deemed effective on the Policy Date stated in the policy data pages.

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 and on any medical questionnaire that becomes a part of this application may not be waived. No knowledge of any fact on the part of any 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.

If my employer or trustee is the owner and beneficiary on this application: I agree to allow my employer to purchase insurance on my life. I understand that my employer or trustee will have all present and future rights of ownership and will also be the beneficiary of the policy, including any attached riders. There is no obligation, on my part, to pay the policy premiums. I acknowledge that as an employee, the employer or trustee has an insurable interest in my life. I understand and agree that my employer will be a direct or indirect beneficiary of all or a portion of the death proceeds payable under the policy and that my administrators, estate, heirs and assignees have no rights to the policy. I understand that the maximum face amount for which I could be insured at the time of issuance is subject to underwriting guidelines, but will not exceed 30 times my salary up to a maximum of $30,000,000. I further authorize my employer or trustee to increase (subject to the maximum indicated above) or decrease the amount of insurance on my life in the future without another consent from me and without further notice to me as long as I am employed by/associated with the employer. I consent to and authorize my employer, trustees, or their successors to continue to be the owner and beneficiary of this policy(ies) indefinitely including after the end of my employment by the employer.

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, business associate having personal information (including physical, mental, drug or alcohol use history) regarding me, the named proposed insured, to provide to the Company, its representatives or reinsurers, any such data. I authorize the Company or its representative to conduct a telephone interview in connection with my application for insurance.

I understand and agree to sign any authorization that is required to authorize any doctor, hospital, clinic, health care provider, laboratory or pharmacy benefit manager having personal information (including physical, mental, drug or alcohol use history, but excluding non-insurance-related HIV testing) regarding the named proposed insured to provide the Company, its representatives or reinsurers any such data. I understand that if I refuse to sign an authorization to release my complete medical record, the Company may not be able to process my application for life insurance coverage.

PART C – AGREEMENT/AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION (CONTINUED)

I authorize the Medical Information Bureau (MIB, Inc.) to furnish the above data to the Company, its representative or its reinsurers. I authorize the Company or its representative 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 agree that this authorization shall be valid for 24 months from the date of this application, unless an earlier date is required by applicable law in the state where the policy is delivered or issued for delivery. 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 a photocopy of this authorization is as valid as the original. I have received a copy of this authorization. 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.

C.O.D. or Advance Premium Paid:

☐ This application is C.O.D. and I have not been given any Conditional Receipt with this application.

☐ I have paid $ _____ as an advance premium with this application which is no less than one month's advance premium and I have been given the Life Insurance Conditional Receipt. In return I have read, understand, and agree to its terms.

☐ I have submitted an Absolute Assignment form with this application and I have been given the Life Insurance 1035 Conditional Receipt. In return I have read, understand, and agree to its terms.

Warning: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

As a proposed owner of this contract, I certify under penalty of perjury that:

1. The number shown on this form is my correct Taxpayer Identification Number (or I am waiting for a number to be issued to me), and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and

   Exempt Payee code (if any): _____
3. I am a U.S. Citizen or other U.S. Person (as defined in the instructions to Form W-9), and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

   FATCA code (if any): _____

You must cross out item 2 above, if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return.

If any proposed owners are not a U.S. person or entity, submit a valid Form W-8BEN (foreign individual) or W-8BEN-E (foreign entity). If you are claiming treaty benefits, provide the required U.S. or foreign tax identifying number as required in the instructions. Failure to submit a valid Form W-8BEN or W-8BEN-E or to provide a required tax identifying number will result in mandatory withholding of 30% of the taxable portion of the payment.

The IRS does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.

Signatures – Please read all of the above Agreements, Authorizations, and Certification before signing below.

Signature of Proposed Insured (If age 15 or over) **X**				
Signature of Parent (If Proposed Insured is under age 16 and Parent has not signed as Owner) **X**				
Signature of Owner(s), if other than Proposed Insured. If corporation, an officer other than the Proposed Insured must sign and include officer's title. If joint ownership or Trust, all joint owners/trustees must sign. If signing as a Trustee include 'Trustee' as title.				
X			Title	
X			Title	
X			Title	
Signed at: City	State	Date	Signature of Licensed Agent/Broker/Representative **X**	License Number
Printed Name of Agent/Broker/Representative				

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AGREEMENT

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I understand that the policy(ies) delivered to me may be from a different issuer than what was listed in the application. I understand and agree that my acceptance of the policy(ies) shall be considered an amendment to this application. Each policy has only one issuing company (Principal Life Insurance Company or Principal National Life Insurance Company) and that issuer is solely responsible for the obligations under that policy.

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I understand and agree that if a policy is issued as other than applied for or without a premium deposit (C.O.D.), then policy coverage is not effective and the Company shall incur no policy liability unless:

1) A policy issued on this application has been physically delivered to and accepted by the owner and the first premium paid; and
2) At the time of such delivery and payment, to the best of the Insured's and my belief, the person to be insured is actually in the state of health and insurability represented in this application, medical questionnaire, or amendment that becomes a part of this application; and
3) The Part D or the Acknowledgment of Delivery form is signed by me and the Proposed Insured (if different than me) and dated at delivery.

If these conditions are met, the policy is deemed effective on the Policy Date stated in the policy data pages.

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 and on any medical questionnaire that becomes a part of this application may not be waived. No knowledge of any fact on the part of any 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.

If my employer or trustee is the owner and beneficiary on this application: I agree to allow my employer to purchase insurance on my life. I understand that my employer or trustee will have all present and future rights of ownership and will also be the beneficiary of the policy, including any attached riders. There is no obligation, on my part, to pay the policy premiums. I acknowledge that as an employee, the employer or trustee has an insurable interest in my life. I understand and agree that my employer will be a direct or indirect beneficiary of all or a portion of the death proceeds payable under the policy and that my administrators, estate, heirs and assignees have no rights to the policy. I understand that the maximum face amount for which I could be insured at the time of issuance is subject to underwriting guidelines, but will not exceed 30 times my salary up to a maximum of $30,000,000. I further authorize my employer or trustee to increase (subject to the maximum indicated above) or decrease the amount of insurance on my life in the future without another consent from me and without further notice to me as long as I am employed by/associated with the employer. I consent to and authorize my employer, trustees, or their successors to continue to be the owner and beneficiary of this policy(ies) indefinitely including after the end of my employment by the employer.

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, business associate having personal information (including physical, mental, drug or alcohol use history) regarding me, the named proposed insured, to provide to the Company, its representatives or reinsurers, any such data. I authorize the Company or its representative to conduct a telephone interview in connection with my application for insurance.

I understand and agree to sign any authorization that is required to authorize any doctor, hospital, clinic, health care provider, laboratory or pharmacy benefit manager having personal information (including physical, mental, drug or alcohol use history, but excluding non-insurance-related HIV testing) regarding the named proposed insured to provide the Company, its representatives or reinsurers any such data. I understand that if I refuse to sign an authorization to release my complete medical record, the Company may not be able to process my application for life insurance coverage.

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PART C – AGREEMENT/AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION (CONTINUED)

I authorize the Medical Information Bureau (MIB, Inc.) to furnish the above data to the Company, its representative or its reinsurers. I authorize the Company or its representative 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 agree that this authorization shall be valid for 24 months from the date of this application, unless an earlier date is required by applicable law in the state where the policy is delivered or issued for delivery. 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 a photocopy of this authorization is as valid as the original. I have received a copy of this authorization. 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.

C.O.D. or Advance Premium Paid:

☐ This application is C.O.D. and I have not been given any Conditional Receipt with this application.

☐ I have paid $ _____ as an advance premium with this application which is no less than one month's advance premium and I have been given the Life Insurance Conditional Receipt. In return I have read, understand, and agree to its terms.

☐ I have submitted an Absolute Assignment form with this application and I have been given the Life Insurance 1035 Conditional Receipt. In return I have read, understand, and agree to its terms.

Warning: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

As a proposed owner of this contract, I certify under penalty of perjury that:

1. The number shown on this form is my correct Taxpayer Identification Number (or I am waiting for a number to be issued to me), and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and

   Exempt Payee code (if any): _____
3. I am a U.S. Citizen or other U.S. Person (as defined in the instructions to Form W-9), and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

   FATCA code (if any): _____

You must cross out item 2 above, if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return.

If any proposed owners are not a U.S. person or entity, submit a valid Form W-8BEN (foreign individual) or W-8BEN-E (foreign entity). If you are claiming treaty benefits, provide the required U.S. or foreign tax identifying number as required in the instructions. Failure to submit a valid Form W-8BEN or W-8BEN-E or to provide a required tax identifying number will result in mandatory withholding of 30% of the taxable portion of the payment.

The IRS does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.

CLIENT COPY

Proposed Insured _____

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

PART B

All references to "you" mean the Proposed Insured. If the Proposed Insured is a minor and the questions are being answered by a parent/guardian on behalf of the minor, "your child" will be substituted for "you" in the questions below.

ACTIVITIES/HEALTH HABITS

1. Please respond to the following questions:
   a. In the last five years have you become a member of the military, military reserve, or National Guard, whether active or inactive, or have you entered into a written agreement to become a member at a future date? ☐ Yes ☐ No
   b. In the last five years have you piloted any type of aircraft, or do you intend to within the next two years? ☐ Yes ☐ No
   c. In the last five years have you engaged in scuba/skin diving, motor sport racing, skydiving, bungee jumping, aerial sports, rock or mountain climbing, or martial arts, or do you intend to within the next two years? ☐ Yes ☐ No
   d. In the last two years have you lived outside the United States or Canada, or do you intend to within the next two years? (If yes, explain below) ☐ Yes ☐ No
   e. In the last two years have you traveled outside the United States or Canada, or do you intend to within the next two years? (If yes, explain below) ☐ Yes ☐ No
2. In the last five years have you:
   a. been in a motor vehicle accident in which you were found to be at fault, pled guilty to or been convicted of driving while intoxicated or pled guilty to or been convicted of more than one moving violation? (If yes, explain below) ☐ Yes ☐ No
   b. pled guilty to or been 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 not prescribed by a physician? ☐ Yes ☐ No
6. In the last ten years have you been advised by a member of the medical profession to limit or discontinue the use of alcohol or drugs; or sought or received counseling or medical treatment because of your alcohol or drug use? ☐ Yes ☐ No

DETAILS TO QUESTIONS 1-6

Quest. #	Include dates and details as requested above.

Proposed Insured _____

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

PART B – (Continued)

INCOME/OCCUPATION

7. Annual income from occupation $ _____ Other Income $ _____
   Source of other income _____ Net Worth (Assets – Liabilities) $ _____
8. Primary occupation _____ Employer _____

This space left blank intentionally

DETAILS TO QUESTIONS 7-8

Quest. #	Include dates and details as requested above.

Proposed Insured _____

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

PART B – (Continued)

MEDICAL HISTORY (Provide details to yes answers, questions 9-10 below)

9. In the last ten years, have you been treated for or been diagnosed by a member of the medical profession 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, sleep apnea, 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
   k. any disease or disorder of the immune system, except those related to the Human Immunodeficiency Virus (AIDS virus)? ☐ Yes ☐ No
10. In the last ten years, have you been diagnosed by a member of the medical profession as having Acquired Immunodeficiency Syndrome (AIDS)? ☐ Yes ☐ No

DETAILS TO QUESTIONS 9-10

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

Proposed Insured _____

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

PART B – (Continued)

MEDICAL HISTORY (Provide details to yes answers, questions 11-16 below)

11. Who is your Primary Physician or medical facility you have seen in the last five years? ☐ None
    a. Name Phone Number

    Street City State Zip

    b. Date last seen, reason and details

12. In the last five years:
    a. have you had any medical tests (excluding tests for HIV (AIDS Virus), 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
13. Are you taking or have you been advised by a member of the medical profession in the last five years to take any medication or supplement (including medicinal marijuana) or treatment not provided in response to a previous question? (If yes, explain below) ☐ Yes ☐ No
14. Current Ht. _____ Wt. _____ Have you lost more than 10 lbs. in the last year? ☐ Yes ☐ No
    If yes, _____ lbs./kgs. Provide details of weight loss. _____
15. a. Has either of your natural parents lived to at least age 60? ☐ Yes ☐ No
    b. Has any of your natural parents or siblings been diagnosed or treated by a member of the medical profession for 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):

16. Have you ever had any life, health or disability insurance rated, modified or declined? (If yes, explain below) ☐ Yes ☐ No

DETAILS TO QUESTIONS 11-16

Quest. #	Include dates and details as requested above.

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

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

Life Insurance Conditional Receipt

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

(In this Receipt, "we", "us", "our", or "the Company" is the Company which issues the policy, Principal Life Insurance Company or Principal National Life Insurance Company, respectively. "Absolute Assignment" is our Absolute Assignment to Effect a Section 1035(a) Exchange form.)

Name of Proposed Insured(s)	Advance payment of: $	Date of Application:

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.**

TERMS AND CONDITIONS:

The Company will pay a death benefit to the beneficiary named in the Application if the proposed insured or the surviving Proposed Insured under survivorship life insurance dies while this Conditional Receipt is in effect, subject to the terms and conditions set out below.

1. CONDITIONS PRECEDENT

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

a) On the Start Date, all Proposed Insureds must be living and insurable, as determined by our underwriters under our underwriting guidelines. If a condition affecting such insurability existed in fact on the Start Date, it shall be considered in the determination of insurability.

b) The premium deposit must be at least one full month's premium for each policy applied for.

c) If the premium deposit is paid at the time the Application is signed, then this Receipt must be issued at the same time as the Application.

d) The premium deposit must be received in our Home Office and must be honored on first presentment for payment.

2. AMOUNT OF COVERAGE

The amount of insurance provided by this Receipt shall be that applied for on the Application, subject to all the **LIMITATIONS** set forth in this Receipt, and will be the lesser of:

a) The amount of all death benefits applied for in the Application, including any accidental or supplemental death benefits, if applicable, or

b) $1,000,000 if the Proposed Insured is insurable on a standard or more favorable basis, or

c) $100,000 if the Proposed Insured is insurable on a basis less favorable than standard, or

d) $500,000 per company if the Proposed Insured is insurable on a standard or more favorable basis, and has an application with Conditional Receipt coverage pending with each of Principal Life Insurance Company and Principal National Life Insurance Company, or

e) $50,000 per company if the Proposed Insured is insurable on a basis less favorable than standard and has an application with Conditional Receipt coverage with each of Principal Life Insurance Company and Principal National Life Insurance Company.

This total death benefit limit applies to all insurance applied for under this and any current Applications to the Company and any other Conditional Receipts that may be in effect with Principal Life Insurance Company and/or Principal National Life Insurance Company.

3. DATE COVERAGE BEGINS

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 requirements are completed. Our initial Application requirements consist of full completion and signing of the Application and all necessary supplements, completion of the telephone application interview, if applicable, and completion of any medical exams and tests required by our published rules.

If premium is submitted after the initial Application is signed and dated, then updated evidence of insurability, subject to our current underwriting guidelines and completion of all our initial Application requirements, is required in order to have insurance under this Receipt. The Start Date would be the earliest date upon which all requirements are completed.

4. DATE COVERAGE ENDS

Any insurance provided by this Receipt ends on the **Stop Date**, which is the **earliest** of:

a) 75th day after the Start Date;

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

c) the date we mail the proposed owner a premium refund and a notice that no policy will be issued on the Application;

d) when policy coverage becomes effective;

e) the date a policy is presented to the proposed owner (whether or not accepted by the proposed owner);

f) the date an Absolute Assignment is received by the Current Insurer(s) and honored on first presentment.

5. HEALTH AND INSURABILITY

This Receipt does not commit Principal Life Insurance Company or Principal National Life Insurance Company to issue any policy. However, in determining whether to issue this policy and on what terms, we will consider no changes in a Proposed Insured's health or insurability occurring between the Start Date and the Stop Date. We have until policy coverage becomes effective to make this determination.

6. LIMITATIONS

a) **Our Liability:** Except as limited by this Receipt, our liability is governed by the terms of the policy(ies) applied for.

b) **Suicide:** No death benefit is payable under this Receipt if the Proposed Insured dies by suicide while sane or insane. In such case, our sole liability shall be to pay the premium we received to the named beneficiary(ies).

c) **Misrepresentation:** 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, any supplemental form, or medical questionnaire that becomes a part of the policy. 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.

d) **Survivorship:** For Survivorship Life insurance, no death benefit will be paid under this Receipt unless both Proposed Insureds have died.

e) **Other:** If any provision of this Receipt is unenforceable under state law, all other terms and conditions shall continue in full force and effect.

7. DEATH PROCEEDS

If an event giving rise to a claim occurs at any time before the Stop Date of this Receipt, coverage will be considered solely under this Receipt even if a policy is issued.

If an event giving rise to a claim occurs at any time after the Stop Date of this Receipt but before policy coverage becomes effective, then the Company shall incur no liability under the Receipt or the Policy even if a policy is issued.

8. PREMIUMS

If a policy is issued from the Application bearing the same date listed on this Receipt and is accepted by the proposed owner, we will apply the premium deposit to the first premium due for such policy. If no policy is put into force but a benefit is paid under this Receipt, we will keep the premium deposit. If no policy is put into force and no benefit is paid under this Receipt, the premium deposit will be refunded. **ALL PREMIUM CHECKS MUST BE MADE PAYABLE TO THE COMPANY AS INDICATED ON PAGE ONE OF THE APPLICATION – DO NOT MAKE CHECK PAYABLE TO THE AGENT OR LEAVE THE CHECK PAYEE BLANK.**

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

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

Notice of Insurance Information Practices

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

This notice explains our information practices. It describes the information we need, possible sources, reasons for collection and how your data is kept confidential. This notice also tells how we process your application. Please keep this notice for your records. The word "you" in this notice means the Proposed Insured.

Overview

Your insurance application contains specific personal questions about you and any named dependents. We need your answers to decide if you qualify for coverage. If you qualify, we determine the coverage for which you are eligible and the cost. This process, known as underwriting, takes into account factors such as physical and mental conditions, medical history, job, age, and hobbies. Underwriting makes it possible to keep rates fair.

Sources and Types of Information

You are the primary source of personal data. We may call you to verify data on your application or to obtain more data. We may ask you about your age, medical history, job, income, habits, hobbies and other personal characteristics. We may contact other sources for personal data, including: (1) spouse, (2) 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 the 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: Underwriting, Principal Life Insurance Company or Principal National Life Insurance Company, P.O. Box 10431, Des Moines, IA 50306-0431 (Telephone 1-800-247-9988, extension 76208).

MIB Pre-Notice

Information regarding your insurability will be treated as confidential. Principal Life Insurance Company, Principal National 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, Suite 400, Braintree, MA 02184-8734.

Principal Life Insurance Company, Principal National 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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Producer Report

Contact Information

Who should we communicate with during the processing of this application?

Field Office Name _____ Number _____

Contact Name _____ Phone Number _____

Email Address _____

Contact Name (if applicable) _____ Phone Number _____

Email Address _____

Producer Phone Number _____

Proposed Insured Information

Name _____

Email Address _____

Relationship to Producer _____

Compensation Details

Print FULL name of all Producers to Receive Compensation	Producer's SSN/Tax ID # (Last 4 #'s required)	Statement/ Detail Code	BGA Paid Thru (If Applicable)	Firm/Corp./BGA Tax ID # (If Applicable)	Commission Split	
					Selling	Servicing
Example: Jonathan Adam Doe	**XXX-XX-1234**	**00002-12345**	**ANY Financial**	**XX-XXXXXXX**	**100%**	**100%**
Primary Servicing Producer (FULL Name)						

Underwriting Requirements

1. **Is this case being submitted for the Principal Accelerated Underwriting Program?** ☐ **Yes** ☐ **No**
2. Has a Part B been completed with Principal either online or by phone? ☐ Yes ☐ No
   If NO: ☐ Request completion of the Part B by the Proposed Insured, using our convenient online Part B Request Form at www.principal.com/partb *(login required)*.
   ☐ Have the Proposed Insured call 1-888-835-3277
3. Which Paramed Provider will complete the routine medical underwriting requirements? ☐ APPS ☐ ExamOne ☐ Other _____
   Would you like Principal to order these requirements? ☐ Yes ☐ No
4. Is English the Proposed Insured's primary/native language? ☐ Yes ☐ No
   If NO, indicate language and submit DD 992, Statement of English Understanding _____
5. Is the Proposed Insured a U.S. Citizen? ☐ Yes ☐ No
   a. If U.S. Citizen, does the Proposed Insured reside outside the U.S. for more than 6 months a year? ☐ Yes ☐ No
   b. Does the Proposed Insured have a Nonimmigrant Visa or other temporary visitor status? ☐ Yes ☐ No
   c. Does the Proposed Insured have a U.S. Permanent Resident Card/Green Card? ☐ Yes ☐ No
   If the Proposed Insured answers NO to the U.S. Citizen question 5 or YES to any question on 5a, 5b, or 5c, then a DD 9091 Foreign Resident Questionnaire is required.
6. If coverage is corporate or trust owned on a California resident, is the insured considered an exempt employee under California law? ☐ Yes ☐ No
7. Do you know, or have reason to believe, that any group of investors plan to obtain any right, title, or interest in any policy issued as a result of this application? Or, to the best of your knowledge, has the Proposed Insured or policyowner ever sold, assigned or transferred ownership in any life policy to an outside investor group? ☐ Yes ☐ No
8. Is this part of a business or private split dollar case (i.e. Buy Sell, Key Person, Executive Bonus, Private Split Dollar, etc.)? ☐ Yes ☐ No
   (If YES, submit the corresponding DD 849 form)

Administrative Requirements

9. If special dating is essential, indicate policy date desired _____ *(If backdating, submit DD 1621)*

☐ Alternate policy to be issued from this application: * _____

☐ Additional policy to be issued from this application: * _____

*If the owner differs, complete a separate application.

Replacement Questions

The following questions are **required** to be answered in the following states: **CA, DE, FL, GA, ID, IL, IN, MA, MI, MN, NV, NY, OK, PA, TN, WA, WY.**

a. Do you know, or have reason to believe, replacement is or may be involved in this transaction? ☐ Yes ☐ No

b. Please answer the following question **about existing life insurance or annuity contracts (including pending coverage provided under a binding receipt).**

Do you have reason to believe any other contract has been or will be assigned, modified, terminated, or be subject to borrowing in connection with the purchase of the insurance applied for? ☐ Yes ☐ No

If YES to a or b, give all details not already provided on the application, including company name, contract number, and what has been or will be done to the existing contract(s):

_____

_____

c. **Do you certify** you have explained to the client that discontinuing or changing an existing contract may involve disadvantages, and that a comparison of existing benefits and proposed benefits should be made before applying for this contract? ☐ Yes ☐ No

☐ Not applicable if a and b are answered NO

The following questions are **required** to be answered in the following states: **AK, AL, AR, AZ, CO, CT, FL, HI, IA, IN, KS, KY, LA, MD, ME, MI, MO, MS, MT, NC, NE, NH, NJ, NM, NY, OH, OK, OR, RI, SC, SD, TX, UT, VA, VT, WI, WV.**

If replacement is or may be involved, list all sales/marketing material (including illustrations) used in the sale and/or shown to the client.

Replacement regulations require replacing insurers to review the sales/marketing material used in the sale and/or shown to the client to ascertain it is substantially complete and accurate for the proposed policy/contract.

Materials Provided by the Company: List all sales/marketing material (including illustrations) used which were obtained from the Home Office or Advisor Digital.

Form # or Other ID	Version # (eg: -6)	Title	Form # or Other ID	Version # (eg: -6)	Title

Note: If this sale involves a variable life product, a prospectus was used in the sale.

Michigan and New York only: Copies of all material must be attached to this form.

Customized and Individualized Materials: These are all sales/marketing materials 1) locally developed or field created, 2) handwritten materials ***and*** 3) materials provided or obtained from The Principal® which were changed, modified, customized or individualized. This includes pre-approved and unapproved materials. **Copies of these materials must be attached to this form.**

8 Digit Home Office Approval #	Date Approved by Home Office	Title & Description	8 Digit Home Office Approval #	Date Approved by Home Office	Title & Description

Use another form to list more if needed.

Producer Statement

I certify 1) The above lists all sales/marketing materials used in this sale and/or shown to this client, 2) originals of all materials used in the sale have been left with the client, and, 3) based on all of the information known to me, replacement does not appear inappropriate for this client.

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 have given the client (Owner) the disclosure of compensation information through: a) the Life Insurance policy illustration/quotation, or b) a copy of the Disclosure of Compensation Information Statement (DD 2695).

Signed at: State	Date	Producer Signature

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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

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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    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.
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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

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:

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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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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

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Disclosure of Compensation Statement

As a result of this sale, your Financial 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 Financial Representative if you have any questions about this compensation.

If you pay compensation directly to your Financial 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.

State Specific Compensation Disclosures:

Arkansas: Compensation from an insurer or other third party means payments, commissions, fees, overrides, bonuses, contingent commissions, loans, stock options, or any other form of valuable consideration, whether or not payable pursuant to a written agreement. Awards, gifts, and prizes shall be considered compensation from an insurer or third party if they are directly tied to performance.

Connecticut: 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.

Georgia: Compensation from the issuing insurer or other third party 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, but shall not mean de minimis gifts of less than $45 in value.

Oregon: 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.

Rhode Island: 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.

Texas: 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 contract or agreement.

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California Medi-Cal Notice

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

NOTICE REGARDING STANDARDS FOR MEDI-CAL ELIGIBILITY

If you or your spouse are considering purchasing a financial product based on its treatment under the Medi-Cal program, read this important message!

You or your spouse do not have to use up all of your savings before applying for Medi-Cal.

Recovery

An annuity purchased on or after September, 1, 2004, shall be subject to recovery by the state upon the annuitant's death under the regulations of the Medi-Cal Recovery Program. Income derived from the annuity must be used to meet the annuitant's share of costs and, if the annuitant is married, the income derived from the annuity may impact the minimum monthly maintenance needs of the annuitant's community spouse. An annuity purchased by a community spouse on or after September 1, 2004, may also be subject to recovery if that spouse is the recipient of past or future Medi-Cal benefits.

Unmarried Resident

An unmarried resident may be eligible for Medi-Cal benefits if he or she has less than $2,000 in countable resources. The Medi-Cal recipient is allowed to keep from his or her monthly income a personal allowance of $35 plus the amount of any health insurance premiums paid. The remainder of the monthly income is paid to the nursing facility as a monthly share of cost.

Married Resident

Community Spouse Resource Allowance: If one spouse lives in a nursing facility, and the other spouse does not live in a facility, the Medi-Cal program will pay some or all of the nursing facility costs as long as the couple together does not have more than $119,220 in countable resources.

Minimum Monthly Maintenance Needs Allowance: If a spouse is eligible for Medi-Cal payment of nursing facility costs, the spouse living at home is allowed to keep a monthly income of at least his/her individual monthly income, or $2,981 in monthly income, whichever is greater.

Fair Hearings and Court Orders

Under certain circumstances, an at-home spouse can obtain an order from an administrative law judge or court that will allow the at-home spouse to retain additional resources or income. The order may allow the couple to retain more than $119,220 in countable resources. The order also may allow the at-home spouse to retain more than $2,981 in monthly income.

Real and Personal Property Exemptions

Many of your assets may already be exempt. Exempt means that the assets are not counted when determining eligibility for Medi-Cal.

Real Property Exemptions

- *One Principal Residence*. One property used as a home is exempt. The home will remain exempt in determining eligibility if the applicant intends to return home someday. The home also continues to be exempt if the applicant's spouse or dependent relative continues to live in it. Money received from the sale of a home can be exempt for up to six months if the money is going to be used for the purchase of another home.
- *Real Property used in a business or trade*. Real estate used in a trade or business is exempt regardless of its equity value and whether it produces income.

Personal Property and Other Exempt Assets

- *IRAs, Keoghs, and other work-related pension plans*. These funds are exempt if the family member whose name it is in does not want Medi-Cal. If held in the name of a person who wants Medi-Cal and payments of principal and interest are being received, the balance is considered unavailable and is not counted. It is not necessary to annuitize, convert to an annuity, or otherwise change the form of the assets in order for them to be unavailable.
- *Personal property used in a trade or business*.
- *One Motor Vehicle*.
- *Irrevocable burial trusts or irrevocable prepaid burial contracts*.

There may be other assets that may be exempt.

This is only a brief description of the Medi-Cal eligibility rules, for more detailed information, you should call your county welfare department. Also, you are advised to contact a legal services program for seniors or an attorney that is not connected with the sale of this product.

Please note: The Federal Government has authorized the State of California, Department of Health Services (DHS) to seek repayment from annuities held by deceased Medi-Cal beneficiaries. The Department may seek repayment from the estate of a deceased Medi-Cal beneficiary for the expenses incurred for all premium payments and services received by the beneficiary's 55th birthday. Premium payments made by the State include, but are not limited to, dental premiums, Medicare premiums, and premium payments made to Medi-Cal managed care plans.

In addition, if you seek Medi-Cal payment for nursing facility services, you may be ineligible for those services if payments from your annuity extend beyond your life expectancy, based on life expectancy tables adopted by the Department of Health Services for this purpose. To find out about these tables, you may contact your local county welfare department.

Finally, the Department of Health Services is currently refining its policy regarding treatment of annuities when determining eligibility for nursing facility services. Any regulatory changes will only impact annuities purchased after the effective date of any regulatory amendments.

Different rules apply to annuities that are qualified retirement arrangements established pursuant to Title 26, Internal Revenue Code, Subtitle A, Chapter 1, Subchapter D, Part 1. In some circumstances, Medi-Cal does not count funds held in an IRA, Keogh, or other work-related retirement arrangement. To find out if Medi-Cal would count your IRA, Keogh, or other work-related retirement arrangements, you may contact your local county welfare department.

I have read the above notice and have received a copy.

Signature of proposed contract owner	Date
Signature of spouse	Date
Signature of legal representative/advisor (if involved in the sale)	Date

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Disclosure Statement For Accelerated Benefits

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

A. **What is an Accelerated Benefit?**

Accelerated benefits are the benefits payable under an Accelerated Benefits Rider attached to a life insurance policy and when an insured provides proof of a terminal illness as described in the policy rider. You can receive up to 75% of the policy face amount less any policy loans or previously paid accelerated benefit with a maximum benefit of $1,000,000.

B. **When can I receive Accelerated Benefits?**

Accelerated benefits are available to terminally ill insureds with life expectancies of 12 months or less from the date payment of an accelerated benefit amount is requested. (Definition of terminal illness may vary in some states. See actual rider for details.)

C. **What payment options are available?**

Accelerated benefits will be paid as a lump sum. Depending on the type of Rider you have on your policy, periodic payments may be made at your request, subject to our approval.

D. **What is the premium for the Accelerated Benefits Rider?**

No additional premium is charged to add the Accelerated Benefits rider to a policy.

E. **What is the administrative expense fee?**

A one time fee up to $150 may be charged only if Accelerated Benefits are paid. If an administrative fee is charged, we will deduct it from the amount of the lump sum Accelerated Benefit or first periodic payment. We will notify you if an administrative expense fee is charged.

PLEASE READ THE FOLLOWING SECTIONS CAREFULLY

F. **How will taking an Accelerated Benefit affect my policy?**

The accelerated benefit payment and its accrued interest are treated as a lien against the policy. The interest rate is the same as your policy loan rate or if your policy does not permit policy loans, your rate will be 8%. However, at no time will the interest rate charged exceed the maximum rate permitted by law.

Your policy remains in force. Death proceeds will be reduced by the accelerated benefit plus accrued interest.

If you have a policy loan, it will first be repaid from the amount of the accelerated benefit. Your cash value will not be reduced, although your access to it will be limited by the amount of the accelerated benefit and any accrued interest. (This does not apply to Term policies which have no cash value.)

Here is an example of how an Accelerated Benefit affects a policy:

Face Amount	**$25,000**
Policy Loan	**$0**
Loan Interest Rate	**8%**
Maximum Accelerated Benefit	**$18,750**

	Face Amount	Cash Value	Benefit & Interest	Death Benefit	Loan Value
Date of Benefit	**$25,000**	**$5,000**	**$18,750**	**$6,250**	**$0**
6 Months Later	**$25,000**	**$5,500**	**$19,500**	**$5,500**	**$0**
1 Year Later	**$25,000**	**$6,000**	**$20,250**	**$4,750**	**$0**

The Accelerated Benefits Rider is subject to state variations and availability. See the rider for full details.

G. **What is the premium for my policy after an Accelerated Benefit?**

Your policy premiums are still due after taking an Accelerated Benefit unless premiums are being waived.

H. **If I have a policy loan, how is it affected?**

The policy loan will first be repaid from the amount of the Accelerated Benefit. Future policy loans will be limited by the amount of the Accelerated Benefit and any accrued interest.

I. **How does termination of my policy affect the Accelerated Benefit?**

Your policy and the Accelerated Benefit Rider must be in force at the time an Accelerated Benefit is paid. Later termination or maturity of your policy does not affect any Accelerated Benefit already paid.

J. **Limitations of the Accelerated Benefit:**

This Accelerated Benefit Rider is NOT a long-term care policy or nursing home insurance policy. The amount this rider pays you may not be enough to cover your medical, nursing home or other bills. There are no restrictions or limitations on the use of the Accelerated Benefits.

Unlike conventional life insurance proceeds, Accelerated Benefits payable under this rider MAY BE TAXABLE. You should consult a personal tax advisor.

Receipt of Accelerated Benefits under this rider MAY AFFECT MEDICAID and SUPPLEMENTAL SECURITY INCOME (SSI) eligibility. Without exercising your option to accelerate benefits, the mere fact that you own an Accelerated Benefit Rider will not in and of itself affect your eligibility for these government programs. However, exercising the option to accelerate benefits and receiving those benefits before you apply for these programs, or while you are receiving government benefits, may affect your initial or continued eligibility. Contact the Medicaid Unit of your local Department of Public Welfare and Social Security Administration Office for more information.

X _____ _____

Signature of Applicant/Policyowner — Date (MM/DD/YYYY) signed by Applicant/Policyowner

X _____ _____

Signature of Joint Applicant/Joint Policyowner — Date (MM/DD/YYYY) signed by Joint Applicant/Joint Policyowner

X _____ _____

Signature of Licensed Agent/Broker/Representative — Date (MM/DD/YYYY) signed by Licensed Agent/Broker/Representative

X _____ _____

Signature of Beneficiary if Irrevocable — Date (MM/DD/YYYY) signed by Irrevocable Beneficiary

_____

Address of Beneficiary if Irrevocable

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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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Authorization for Release of Personal Health Information – All States
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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.

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.

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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Payment Authorization for Electronic Fund Transfers

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

FOR LIFE NEW ISSUE POLICIES ONLY

NOTE: We are unable to draw funds if any of the required fields marked with an asterisk (*) are left blank, incomplete, or if this form is not signed. Any Conditional Receipt coverage will be void. Refer to the Conditional Receipt (AA 3432) for terms and conditions.

***Choose ONE of the following:**

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

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

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

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

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

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

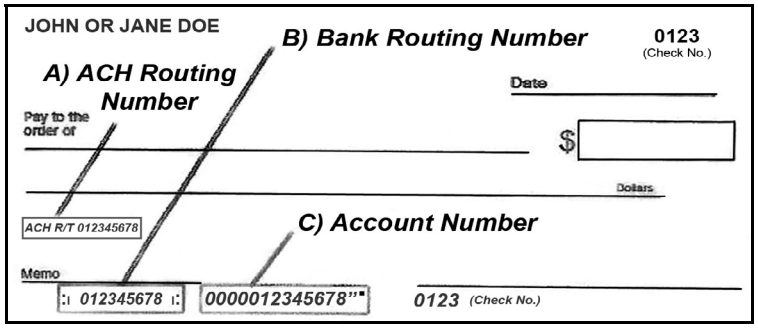
*Type of Account:

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

*Account Ownership:

☐ **Personal** ☐ **Organization**

Sample Check



Complete Your Bank Information Below, or Submit Voided Check

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

_____

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

_____

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

_____

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

I understand if the withdrawal requests are dishonored by the Company, whether with or without cause, that the Company shall be under no liability. This authorization will remain in effect until cancelled either by myself, the Company or the financial institution. Any applicable refunds will be refunded back to the policy owner regardless of who the payee is.

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

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

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Secondary Addressee Designation Notice

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

Thank you for applying for life insurance with our Company. If your application is approved and a policy is issued, you have the right to designate at least one person, in addition to yourself, to receive copies of any grace period notices and termination letters sent to you regarding your life insurance policy.

Proposed Insured Name _____ File No. _____

Secondary Addressee Name _____

Address _____

City _____ State _____ Zip _____ ( ) Telephone No. _____

If you do not want to designate another person as a Secondary Addressee, no action is required on your part.

If you have any questions about this notice, you may contact your representative for additional information, or you may contact our Home Office at this toll-free number: 800-247-9988.

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Authorization to Disclose Health-Related Information to the Field Office and Financial Professional

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

_____

Name of Proposed Insured

I hereby authorize the Company, their employees, officers, and affiliates to disclose any and all medical information ("Information"), which has been collected by the Company in connection with my current request for life insurance to the Field Office and Financial Professional submitting that life insurance request.

Information includes, but is not limited to, the results of any test results, my medical care, treatment or surgery and prescription medications. Additional information that may be disclosed includes information regarding mental health conditions and alcohol or drug abuse information as permitted by law. Information regarding HIV test results, AIDS and HIV related conditions will not be disclosed under the terms of this Authorization. I understand that information that may have been subject to privacy rules adopted and subsequently amended by the United States Department of Health and Human Services pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) or other laws, once disclosed, may no longer be covered by those rules and may be subject to re-disclosure by the recipient. It is my understanding that the purpose of this authorization is to facilitate submission of this Information by the Field Office and Financial Professional, or their authorized representatives to other insurers to evaluate an application for insurance on my life.

I understand that the Company assumes no liability with respect to any application for insurance to other companies and makes no representation as to the competitiveness or accuracy of the Information. I also understand that the Company will only provide disclosures as permitted by law, and, in its sole discretion, may not provide all Information in its possession. It is my responsibility to disclose any and all requested medical information to any insurance carrier to which I apply for insurance coverage.

I further understand that the Company's privacy policy does not extend to the copy of the Information provided to the Field Office and Financial Professional.

This authorization is effective as of the date it is signed and shall continue for twenty-four (24) months unless otherwise provided by law. I also understand that I may revoke this authorization by providing written notification to the Company at the address provided above, which revocation shall be subject to the rights of the Company, and to the extent the Company has acted in reliance on the authorization prior to notice of revocation.

A copy of this authorization shall be as valid as the original.

My signature below indicates that I have read and understand this authorization.

☐ **I <u>DO</u> hereby authorize the Company to disclose any and all medical information to the Field Office and Financial Professional.**

☐ **I <u>DO NOT</u> authorize the Company to disclose any and all medical information to the Field Office and Financial Professional.**

X _____ _____

Signature of Proposed Insured | Date

Principal®

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

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

Beneficiary Information – For Life NEW ISSUE Policies Only

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

Policy Information

Policy Number | On the Life of

Primary Designation *(Additional designations can be provided by completing another DD 9180 form)*

A Person or Corporation

1. Beneficiary Full Name | Relationship | Date of Birth | Share % | Social Security Number

Address | City | State | Zip Code

Primary Phone Number ( ) | Secondary Phone Number ( ) | Email Address

Trustee Name | Trustee Address | Date of Trust

2. Beneficiary Full Name | Relationship | Date of Birth | Share % | Social Security Number

Address | City | State | Zip Code

Primary Phone Number ( ) | Secondary Phone Number ( ) | Email Address

Trustee Name | Trustee Address | Date of Trust

3. Beneficiary Full Name | Relationship | Date of Birth | Share % | Social Security Number

Address | City | State | Zip Code

Primary Phone Number ( ) | Secondary Phone Number ( ) | Email Address

Trustee Name | Trustee Address | Date of Trust

Contingent Designation *(Additional designations can be provided by completing another DD 9180 form)*

In the event said Primary Beneficiary(ies) predecease me, I designate the following as Contingent Beneficiary(ies):

A Person or Corporation

1. Beneficiary Full Name | Relationship | Date of Birth | Share % | Social Security Number

Address | City | State | Zip Code

Primary Phone Number ( ) | Secondary Phone Number ( ) | Email Address

Trustee Name | Trustee Address | Date of Trust

2. Beneficiary Full Name | Relationship | Date of Birth | Share % | Social Security Number

Address | City | State | Zip Code

Primary Phone Number ( ) | Secondary Phone Number ( ) | Email Address

Trustee Name | Trustee Address | Date of Trust

Owner Information *(Only Required on Group Life Conversion Applications)*

Name | Date of Birth

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Des Moines, IA 50306-0431

Electronic Consent Disclosure

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

Voluntary Electronic Opt-in Consent Disclosure

By completing and signing this document, you are voluntarily consenting to electronically receive documents related to an application for life insurance and administration of insurance policies, including applications, notices, disclosures, authorizations, acknowledgements and delivery receipts. Any document that we send by electronic means, which complies with applicable law, will have the same force and effect as if that document was sent in paper format.

You may withdraw your consent to do business electronically, request a free paper copy of documents annually, or report a change in your email address by contacting us by one of the methods outlined below:

- Email: IndLifeService@exchange.principal.com
- Telephone: 1-800-654-4278
- Paper: P.O. Box 10431, Des Moines, IA 50306-0431
- On the Company's website at: www.principal.com

Consent to Receive Electronic Transmission of Documents

☐ **I (Proposed Insured) consent to receive electronic transmission of documents**

☐ **I (Owner) consent to receive electronic transmission of documents**

For purposes of receiving electronic transmission of documents from the Company, as set forth above, the email address(es) provided below are to be used:

Proposed Insured Email Address

Proposed Insured Signature | Date

Owner Email Address

Owner Signature | Date

Principal®

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Principal Life Insurance Company
Members of Principal Financial Group®

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

Entity/Organization Owned Policies – Know Your Customer Questionnaire

The U.S. Department of the Treasury requires us to "know our customer' by obtaining information about Entities/Organizations when the Entity/Organization is to be an Owner of a life or disability insurance policy. Please complete the form in its entirety.

Policy Number(s), *if known*	Proposed Insured Name(s)

Legal Information about the Entity/Organization

Legal Name

Doing Business As (DBA), if any

Address (No P.O. Box)

City	State	Zip Code	Country

NAICS Code (if known) www.census.gov/naics	Employer Identification Number (EIN)

Additional Information about the Entity/Organization

1. Is the Entity/Organization publicly traded, or owned by a 51% majority or more of a different Entity/Organization that is publicly traded on the U.S. Stock Exchange? ☐ Yes ☐ No
2. Is the Entity/Organization registered with the SEC (i.e., registered investment advisor, broker dealer), a state regulated insurance company, a U.S. federal or state regulated bank, a department or agency of the United States, or of any State? ☐ Yes ☐ No
3. If the answer to both 1 and 2 is No, please answer 3a and 3b:
   a) Is the Entity/Organization:
      Owned by a non-US person or foreign Entity? ☐ Yes ☐ No
      Non-governmental Organization (NGO), Foundation or Charity? ☐ Yes ☐ No
      Foreign Financial Institution? ☐ Yes ☐ No
   b) List the names of any party that owns a 25% or greater equity interest (direct ownership or beneficial owner) in the Entity/Organization.

First Name	Middle Initial	Last Name (if an individual)	DOB/Year of Birth

Entity/Organization Name (if an entity)	Entity/Organization TIN

4. Does the Entity/Organization have operations in, or provide services to or from, any of the following countries or regions: Cuba, Iran, Crimean region of Ukraine, North Korea, or Syria? ☐ Yes ☐ No

I certify the organization/entity is in compliance with all state-required formalities, and the organization/entity has not been dissolved, nor is a dissolution request anticipated to be filed with the state and is in existence as of the date of signature.

Under penalty of perjury, the undersigned verify/verifies that all information contained herein is true and complete and agree/agrees to indemnify Principal Financial Group, Inc. (Principal) and its affiliates and hold them harmless from a liability arising from any action or inaction taken in reliance on this Certification. The undersigned agree/agrees to release and hold harmless Principal from any and all claims, demands, controversies, action, and losses including income taxes, court costs, and reasonable attorney's fees that may arise. Any holder of the Certification may rely solely on the statements made herein.

Signature Information

Signature of Organization/Entity Representative	Printed Name of Organization/Entity Representative	Date (mm/dd/yyyy)