☐ **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 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<br>☐ Male ☐ Female | Date of Birth<br>/ / |
|---|---|---|
| Primary Residence Street Address | Social Security Number<br>- - | Birthplace (State, or Country if not U.S.) |
| City, State, Zip Code | Driver's License Number | State Issued |
| Home Phone Number<br>( ) | Occupation | |
| Work Phone Number<br>( ) | Workplace Zip Code | |

### 2. BASIC COVERAGE APPLIED FOR

Product _____

Face Amount (excluding riders)
$ _____

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

Policy Planned Premium $ _____

Premium Frequency: (choose one)
☐ Annual ☐ Semi Annual ☐ Quarterly ☐ Single Pay

☐ EFT (complete EFT form + attach sample check)

List Bill Number _____
☐ Annual ☐ Semi Annual ☐ Quarterly ☐ Monthly

Unscheduled Premium $ _____

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

- ☐ Accidental Death – Amount $ _____
- ☐ Accounting Benefit
- ☐ Alternate Cash Surrender Value
- ☐ Change of Insured
- ☐ Children Term – Amount $ _____
- ☐ Four Year Term
- ☐ 20 Year Premium Guarantee
- ☐ Policy Split Option
- ☐ Salary Increase – Amount $ _____
- ☐ Single Life Term – Amount $ _____
- ☐ Waiver of Premium/Specified Premium
- ☐ Waiver of Monthly Deductions/Monthly Policy Charges
- ☐ _____
- ☐ _____

### 4. BENEFICIARY INFORMATION

| Primary Beneficiary | Relationship to Proposed Insured |
|---|---|
| | |
| Contingent Beneficiary | Relationship to Proposed Insured |
| | |
| Single Life Term Rider Beneficiary | Relationship to Proposed Insured |

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*) |
| **Joint Owner Name** | Relationship to Proposed Insured |
| Primary Residence Street Address | Taxpayer Identification Number |
| City, State, Zip Code | Date of Birth |
| **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 diagnosed 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 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, 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 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. 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 administrators, estate, heirs and assignees have no rights to the policy or any policy proceeds. I understand that the maximum face amount for which I could be insured at the time of issuance is generally not more than 30 times compensation, up to a maximum of $30,000,000, subject to underwriting guidelines. I further authorize my employer or trustee to increase 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 the employer. I consent to and authorize my employer, trustees, or its 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, or any other organization, institution or person 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, pharmacy benefit manager or any other institution having personal information (including physical, mental, drug or alcohol use history) 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. 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:** It is a crime to provide false, misleading, or incomplete information to an insurance company for the purpose of defrauding the company or any other person. Penalties include imprisonment and/or fines and denial of insurance benefits.

**OWNER TAXPAYER IDENTIFICATION NUMBER CERTIFICATION:** As proposed owner of this contract, I certify under penalties of perjury: (1) The taxpayer identification number shown on this application is correct, (2) I am not subject to IRS backup withholding, and (3) I am a U.S. person (which includes a U.S. resident alien). If subject to backup withholding complete W-9. If not a U.S. person complete W-8. **The Internal Revenue Service 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)<br>**X** | | | | |
| Signature of Parent (If Proposed Insured is under age 18 and Parent has not signed as Owner)<br>**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<br>**X** | License Number |
| Cosignature by resident Licensed Agent/Broker/Representative, if applicable in your state<br>**X** | | | Date | License Number |

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 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, 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 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. 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 administrators, estate, heirs and assignees have no rights to the policy or any policy proceeds. I understand that the maximum face amount for which I could be insured at the time of issuance is generally not more than 30 times compensation, up to a maximum of $30,000,000, subject to underwriting guidelines. I further authorize my employer or trustee to increase 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 the employer. I consent to and authorize my employer, trustees, or its 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, or any other organization, institution or person 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, pharmacy benefit manager or any other institution having personal information (including physical, mental, drug or alcohol use history) 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.

CLIENT COPY

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

**OWNER TAXPAYER IDENTIFICATION NUMBER CERTIFICATION:** As proposed owner of this contract, I certify under penalties of perjury: (1) The taxpayer identification number shown on this application is correct, (2) I am not subject to IRS backup withholding, and (3) I am a U.S. person (which includes a U.S. resident alien). If subject to backup withholding complete W-9. If not a U.S. person complete W-8. **The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.**

CLIENT COPY

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

Proposed Insured _____

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

**PART B**

All references to "you" mean the Proposed Insured.

**ACTIVITIES/HEALTH HABITS**

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

**DETAILS TO QUESTIONS 1-6**

| Quest. # | Include dates and details as requested above. |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |

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

Proposed Insured _____

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

**PART B –** (Continued)

**INCOME/OCCUPATION**

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

***This area left blank intentionally.***

**DETAILS TO QUESTIONS 7-8**

| Quest. # | Include dates and details as requested above. |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |

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

Proposed Insured _____

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

**PART B –** (Continued)

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

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

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

Proposed Insured _____

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

**PART B –** (Continued)

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

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

    Street City State Zip

    b. Date last seen, reason and details

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

**DETAILS TO QUESTIONS 11-16**

| Quest. # | Include dates and details as requested above. |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |

**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:<br>$ | 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**
P.O. Box 10431, Des Moines, IA 50306-0431
www.principal.com
*Members of Principal Financial Group®*

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

# 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 TeleApp interview with The Principal® been scheduled to complete Part B / II? | ☐ Yes | ☐ No |
| | *If NO, select scheduling option:* ☐ Have the Proposed Insured call 1-888-TELEAPP for immediate interview. ☐ Schedule a future interview for the Proposed Insured by accessing our online Web scheduler at www.principal.com/teleapp (login required). | | |
| 3. | Which Paramed Provider will complete the routine medical underwriting requirements? ☐ APPS ☐ ExamOne ☐ Other _____ | | |
| 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.)? *(If YES, submit the corresponding DD 849 form)* | ☐ Yes | ☐ No |

## 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: **AK, AL, AR, AZ, CA, CO, CT, DE, GA, HI, IA, ID, IL, KS, KY, LA, MA, MD, ME, MN, MO, MS, MT, NC, NE, NH, NJ, NM, NV, OH, OR, PA, RI, SC, SD, TN, TX, UT, VA, VT, WA, WI, WV, 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, 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 |
|---|---|---|
| | | |

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

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

***Notice and Consent***

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

---

**Information Form For Insurance Proposed Insured**

Before consenting to testing, please read the following information:

To evaluate your insurability, the above company (the Insurer) has requested that you be tested. Tests which may be performed include determinations of blood cholesterol and related lipids (fats) and screening for liver or kidney disorders, diabetes, and immune disorders. One of the tests to be performed on this sample will be a test to determine the presence of human immunodeficiency virus (HIV) antibodies. By signing and dating this form you agree that this test may be done and that underwriting decisions will be based on the test result. The HIV Antibody Test consists of a series of three tests as outlined below which will be performed by a licensed laboratory through a medically accepted procedure.

**AIDS:**

Acquired Immunodeficiency Syndrome (AIDS) is a life-threatening disorder of the immune system, caused by a virus, HIV. The virus is transmitted by sexual contact with an infected person, from an infected mother to her newborn infant or by exposure to infected blood (as in needle sharing during IV drug use). Persons at high risk of contracting AIDS include males who have had sexual contact with another man, intravenous drug users, hemophiliacs, and sexual contacts with any of these persons. AIDS does not typically develop until a person has been infected with HIV for several years. A person may remain free of symptoms for years after becoming infected. If symptoms do develop, they may include fever (including night sweats), weight loss, swollen lymph glands, fatigue, diarrhea or white spots in the mouth.

**The HIV Antibody Test:**

**Purpose: This test is being run to determine whether you may have been infected with HIV. If you are infected, you are probably not insurable. This test is not a test for AIDS, AIDS can only be diagnosed by medical evaluation.**

When an HIV Antibody test is performed, it will be performed only by a licensed laboratory and according to the following medical protocol:

1) An initial ELISA test will be done. If such test is negative, a negative finding will be reported by the laboratory to the Insurer.
2) If the initial ELISA test is positive, another ELISA test will be performed.
    a) If the second ELISA test is also positive, a Western Blot test will be performed to confirm the positive results of the two ELISA tests.
    b) If the second ELISA test is negative, a third ELISA test will be performed. If the third ELISA test is positive, a Western Blot test will be performed to confirm the previous positive results. If the third ELISA test is negative, a negative result will be reported to the Insurer.
3) Only if at least two ELISA tests and a Western Blot test are all positive will the result be reported as positive. All other results will be reported as negative by the laboratory to the Insurer.

This test is not a test for AIDS. It is a test for antibodies to the HIV virus, the causative agent for AIDS, and shows whether you have been exposed to the virus. A positive test result does not mean that you have AIDS but shows that the risk that you will develop problems with your immune system is significantly increased

**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.

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.

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

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

***Counseling Resources***

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

## COUNSELING RESOURCES LIST

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Salud Pura La Cente
10 Alexander Street
Watsonville, CA 95076

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Aquarinn Effort, Inc.
Sacramento County
1304 "O" Street
Sacramento, CA

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

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

***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 |

Client Copy

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

***Disclosure Statement For Terminal Illness Death Benefit Advance Rider (Accelerated Benefit)***

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 a Terminal Illness Death Benefit Advance?**

A terminal illness death benefit advance is the accelerated benefits payable under a Terminal Illness Death Benefit Advance Rider attached to a life insurance policy 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 a Terminal Illness Death Benefit Advance?**

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.

D. **What is the premium for the Terminal Illness Death Benefit Advance 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 will be charged only if Accelerated Benefits are paid. If an administrative fee is charged, we will deduct it from the amount of the Accelerated Benefit.

---

**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 Terminal Illness Death Benefit Advance 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 Terminal Illness Death Benefit Advance Rider:**

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.

In no instance can an accelerated benefit advance under any other accelerated benefit rider you may have on your policy be advanced once you have exercised the Terminal Illness Death Benefit Advance Rider.

**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

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

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

***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

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

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

# *Authorization for Release of Personal Health Information – All States*

(Applicable to Individual Life and Disability Insurance Customers)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

## CLIENT COPY

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

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

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

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

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

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

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

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

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

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

**Proposed Insured/Patient Copy – Sign Original** / /

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

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

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

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

# *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.

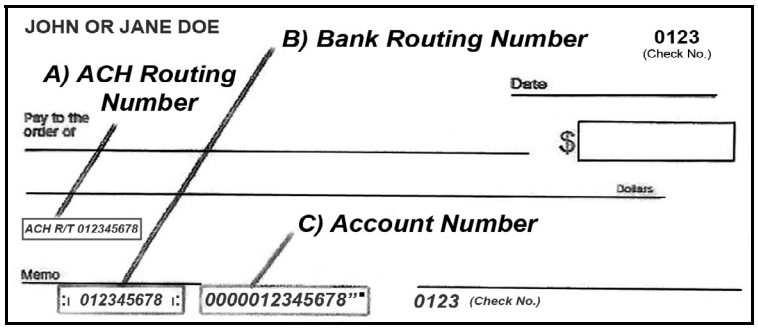
**If Initial Modal/Premium and Monthly Recurring EFT are to be drafted from different accounts, complete a separate form for each.**

## *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.)

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

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

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

***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.

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

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

***Policyowner Tax Verification***

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

**To comply with United States laws and regulations, the Company is required to obtain the following information for EACH Owner connected to a policy. Complete additional form(s) if needed. Submit all form(s) to the Company's Home Office for processing.**

Policy Number(s): _____ _____ _____ _____ _____

## OWNERSHIP INFORMATION

| Owner Name | Are you a U.S. Person or U.S. Entity*? | Taxpayer Identification Number |
|---|---|---|
| **#1** | ☐ Yes ☐ No | |
| **#2** | ☐ Yes ☐ No | |
| **#3** | ☐ Yes ☐ No | |

**A U.S. Person is a U.S. Citizen or a U.S. Resident Alien. A U.S. Entity is an entity organized in the U.S.*

- If you are an INDIVIDUAL, but not a U.S. Citizen or Resident Alien, **STOP HERE** and submit a **W-8**.
- If you are an ENTITY, but not organized in the U.S., **STOP HERE** and submit a **W-8BEN-E**.

## OWNER TAXPAYER IDENTIFICATION NUMBER CERTIFICATION

Under penalties of perjury, I certify 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, or

   Exemption Payee code (if any): _____

   ☐ I have been notified by the IRS that I am currently subject to backup withholding. **NOTE:** You must check this box if you have been notified by the IRS that you are currently subject to backup withholding.
3. I am a U.S. citizen or other U.S. person (as defined in the instructions), and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

   Exemption from FATCA reporting code (if any): _____

**Instructions for completing this form may be found at www.irs.gov/pub/irs-pdf/iw9.pdf.**

## SIGNATURES

**X** _____ _____
Signature of Owner #1 — Date MM/DD/YYYY

**X** _____ _____
Signature of Owner #2 (if applicable) — Date MM/DD/YYYY

**X** _____ _____
Signature of Owner #3 (if applicable) — Date MM/DD/YYYY

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

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

***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.

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

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

***Replacement Notice***

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

## NOTICE REGARDING REPLACEMENT

## REPLACING YOUR LIFE INSURANCE POLICY OR ANNUITY?

Are you thinking about buying a new life insurance policy or annuity and discontinuing or changing an existing one? If you are, your decision could be a good one – or a mistake. You will not know for sure unless you make a careful comparison of your existing benefits and the proposed benefits.

Make sure you understand the facts. You should ask the company or agent that sold you your existing policy to give you information about it.

Hear both sides before you decide. This way you can be sure you are making a decision that is in **your** best interest.

We are required by law to notify your existing company that you may be replacing their policy.

The following policy(ies) may be replaced as a result of this transaction.

| Insurer / Other Company | Policy / Contract Number | Insured / Annuitant |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

Owner's / Applicant's Signature _____ Date _____

Joint Owner's / Joint Applicant's Signature _____ Date _____

Marketer's / Agent's Signature _____ Date _____

**Print and Distribute:** 1 to owner, 1 to marketer, 1 to Principal

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

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

***Supplemental Statement***

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

Name

| Date of Birth | Date Application Signed | File Number(s) |
|---|---|---|
| | | |

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

☐ Yes ☐ No 2. Have you applied for other life, disability or health insurance since the date of application? If yes, please provide details including carrier name, amount applied for, action taken, and the intent of the coverage that was applied for with the other carrier.

I represent that all statements recorded above are true and complete to the best of my knowledge and belief and were correctly recorded before I signed my name below. I understand and agree that these statements will become part of my application and any policy issued on it.

| Signature of Proposed Insured (If age 15 or over)<br>**X** | | |
|---|---|---|
| Signature of Parent (If Proposed Insured is under age 18)<br>**X** | | |
| Date | Signature of Licensed Agent/Broker/Representative<br>**X** | License Number |

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

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

***Application Supplement Life Insurance***

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

## CONFIDENTIAL FINANCIAL STATEMENT

1. Name of Proposed Insured _____ Amount of Insurance Requested _____

2. Business Insurance: Answer questions 2, 4, 5, 6

☐ Key Person ☐ Buy/sell ☐ Stock Redemption ☐ Deferred Compensation
☐ Required by creditor (debt protection) ☐ Split Dollar ☐ Other _____

3. Personal Insurance: Answer questions 3, 4, 6, 7 ☐ Estate Liquidity

☐ Final Expenses ☐ Family Income Replacement ☐ Charitable Giving
☐ Mortgage ☐ Retirement Plan ☐ Other

4. Explain in detail the need for the insurance requested _____

Is amount applied for based on recommendation from Sales Services? ☐ Yes ☐ No

5. Is proposed insured owner in business? _____ % of Ownership? _____

Are other partners, corporate officers or keypersons insured or being insured with similar amounts? ☐ Yes ☐ No
If "No," why not? _____

For other owners, list:

| Name | Title | % Ownership | Amount of Business Insurance In Force |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

Net worth of business: Book value $ _____ Fair Market Value $ _____

How was the value of the business determined? _____

Gross Annual Sales $ _____ Net Annual Income of Business (before taxes) $ _____

Is insurance required by creditor? ☐ Yes ☐ No Amount of loan $ _____

6. Earned Income:

| | Last Year | Previous Year |
|---|---|---|
| Salary | $ | $ |
| Bonus | | |
| Other | | |
| Unearned Income (interest, rentals, etc.) | | |
| Total | $ 0.00 | $ 0.00 |

7. Current personal financial status

Assets at current market value $ _____
Liabilities $ _____
NET WORTH $ 0.00

I represent that these statements are true and complete to the best of my knowledge and belief. They are a part of my insurance application.

Signature of Proposed Insured _____ Date _____ Signature of Licensed Agent/Broker/Representative

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

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

***Employer or Employer Trust Owned – Consent to be Insured***

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

| **Employer Information** | **Proposed Insured Name** |
|---|---|
| Employer Name | (First, Middle, Last) |

I agree to allow the Employer or trustee of a Trust established or sponsored by the Employer to purchase insurance on my life. I understand that the Employer or trustee will have all present and future rights of ownership and will also be the beneficiary of the policy. There is no obligation, on my part, to pay the policy premiums. I acknowledge the Employer or trustee will have an insurable interest on my life.

I understand and agree that the 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 further authorize the Employer or trustee to increase (subject to the maximum indicated below) 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 the Employer or trustee or their successors to continue to be the owner and beneficiary of this policy(s) indefinitely including after the end of my employment by the Employer.

*Check Appropriate Box Below:*

**I understand that the maximum face amount for which I could be insured at the time of issuance is:**

☐ Not more than 30 times compensation, up to a maximum of $30,000,000 subject to underwriting guidelines or

☐ Not to exceed $ _____ face amount, subject to underwriting guidelines.

**Proposed Insured Details**

| Date of Birth (mm/dd/yyyy) / / | Taxpayer Identification Number - - |
|---|---|
| Work Address, including Zip Code | |

Are you a U.S. citizen or have a permanent U.S. resident status? ☐ Yes ☐ No

Do you currently reside in the U.S.? ☐ Yes ☐ No

If either of the above answers are No, please provide details: _____

_____

My signature indicates that I have read and understand this consent form and that I willingly choose to consent as indicated above.

| Signature of Proposed Insured | Date |
|---|---|
| | |

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

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

***Illustration Disclosure***

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

**Complete this section if an illustration was viewed but not provided**

I certify that I displayed a computer screen illustration for _____ that complies with state requirements and for which no hard copy was furnished. The illustration was based on the following personal and policy information:

1. Gender ..... ☐ Male ☐ Female
2. Age ..... _____
3. Tobacco Status and Risk Class ..... _____
4. Type of Policy/Product ..... _____
5. Initial Death Benefit ..... $ _____
6. Premium Amount ..... $ _____
7. Premium Frequency ..... ☐ EFT ☐ Annual ☐ Semi Annual ☐ Quarterly ☐ Single Pay
8. Planned Premium Duration ..... _____ (No. of Years to Pay)
9. Riders ..... _____

Signature of Agent | Date

I acknowledge that I viewed a computer screen illustration based on the information as stated above. No hard copy of the illustration was furnished. I understand that an illustration conforming to the policy as issued will be provided to me no later than at the time the policy is delivered.

Signature of Policyowner | Date

Signature of Joint Policyowner | Date

**********

**Complete this section if no illustration was provided at the time of application**

I have not received an illustration of the policy for which I am applying. I understand that an illustration that matches the policy will be provided to me no later than the time the policy is delivered.

Signature of Policyowner | Date

Signature of Joint Policyowner | Date

I certify that an illustration of the policy being applied for was not presented to the applicant. I also certify that an illustration that matches the policy will be provided to the applicant no later than the time the policy is delivered.

Signature of Agent | Date

HOME OFFICE COPY

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

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

***Illustration Disclosure***

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

**Complete this section if an illustration was viewed but not provided**

I certify that I displayed a computer screen illustration for _____ that complies with state requirements and for which no hard copy was furnished. The illustration was based on the following personal and policy information:

1. Gender ..... ☐ Male ☐ Female
2. Age ..... _____
3. Tobacco Status and Risk Class ..... _____
4. Type of Policy/Product ..... _____
5. Initial Death Benefit ..... $ _____
6. Premium Amount ..... $ _____
7. Premium Frequency ..... ☐ EFT ☐ Annual ☐ Semi Annual ☐ Quarterly ☐ Single Pay
8. Planned Premium Duration ..... _____ (No. of Years to Pay)
9. Riders ..... _____

| Signature of Agent | Date |
|---|---|
| | |

I acknowledge that I viewed a computer screen illustration based on the information as stated above. No hard copy of the illustration was furnished. I understand that an illustration conforming to the policy as issued will be provided to me no later than at the time the policy is delivered.

| Signature of Policyowner | Date |
|---|---|
| | |

| Signature of Joint Policyowner | Date |
|---|---|
| | |

**********

**Complete this section if no illustration was provided at the time of application**

I have not received an illustration of the policy for which I am applying. I understand that an illustration that matches the policy will be provided to me no later than the time the policy is delivered.

| Signature of Policyowner | Date |
|---|---|
| | |

| Signature of Joint Policyowner | Date |
|---|---|
| | |

I certify that an illustration of the policy being applied for was not presented to the applicant. I also certify that an illustration that matches the policy will be provided to the applicant no later than the time the policy is delivered.

| Signature of Agent | Date |
|---|---|
| | |

CLIENT'S COPY