



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

## Disability Insurance Adjustment or Reinstatement Application

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

*Please follow the instructions below to expedite the application process.*

### For Non-Underwritten Adjustments

- Complete questions 1 – 4 on **Part A** of the application and obtain signature(s) on **Part C**. Answer all questions legibly in blue or black ink. The **applicant** is required to initial any changes.
- Complete the **Producer Report** and all **supplemental forms** (if applicable).
- Provide the Conditional Receipt if premium is collected at the time of the application or if the pre-approved Payroll Deduction Form (Applicable to Multi-Life cases only) is used.

### For Underwritten Adjustments

- Complete **Part A** of the application and obtain signatures on **Part C**. Answer all questions legibly in blue or black ink. The **applicant** is required to initial any changes.
- Complete the **Producer Report** and all **supplemental forms** (if applicable).
- If utilizing the TeleApp process, please call toll free **1-888-835-3277** (1-888-TELEAPP) to schedule the telephone application interview. A TeleApp counselor will ask the questions from Part B (medical/habits information) of the application.

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

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

- Submit the **Producer Report, Part A, Part B** (if applicable), **Part C and all supplemental forms** (if applicable). Please do not duplex the application pages and only print data and wording on one side of a page.
- Submit verification of income/financial documentation (if applicable).
- For Reinstatements or a combination Reinstatement/Adjustment, a minimum of three months premium must be submitted.
- For Adjustments, submit the **Premium Summary Report** of the DI Illustration. Submitting this report helps expedite the underwriting process.
- Provide the Conditional Receipt if premium is collected at the time of the application or if the pre-approved Payroll Deduction Form (Applicable to Multi-Life cases only) is used.
- If multiple producers are indicated on the Producer Report (question 3, page 1) the **1<sup>st</sup> year and renewal commissions**, including contractual benefit increases such as FBI and BU, are paid per the split indicated. The producer listed on the 1<sup>st</sup> line in the box indicating **Servicing Producer**, is designated to provide policy service and receive all applicable service correspondence sent to the client. To change the **recipient of commissions** for new adjusted coverage and subsequent contractual increases such as FBI and BU, an **Agent of Record Change** is required and should be submitted to Marketer Services.

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# Disability Insurance Adjustment or Reinstatement Producer Report

Insured \_\_\_\_\_ Policy Number \_\_\_\_\_

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

Contact Name	Contact's Phone Number	Contact's Email Address
--------------	------------------------	-------------------------

**2. Producer Information**

Producer's Office Name	Producer's Principal Office Number	Producer's Phone Number
------------------------	------------------------------------	-------------------------

**3. Compensation Information**

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

**4. Additional Information**

**a. Discounts (check those that apply)**

- Multi-Life (List Bill/three or more lives)  
 10%    15%    20%    25%    30%  
  Association (If approved in your state)  
 Employer's Name \_\_\_\_\_ Association Name \_\_\_\_\_  
 Employer's Address \_\_\_\_\_ Association Number \_\_\_\_\_  
 Employer Tax ID \_\_\_\_\_  
 Mental/Nervous (Not available in Texas)  
 Select Occupation  
 List Bill Number (if known) \_\_\_\_\_

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

**c. Proposed Insured's relationship to the Producer/Licensed Representative** \_\_\_\_\_

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





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# Disability Insurance Adjustment or Reinstatement Application - PART A

## 1. Personal Information about the Proposed Insured

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

Have you smoked cigarettes or used a nicotine patch or gum within the past 12 months? .....  Yes     No  
 Are you a U.S. citizen?     Yes     No

## 2. Indicate the Purpose of This Application

- Adjustment only (answer Questions 3 - 8)                       Reinstatement only (answer Questions 4 - 8)  
 Adjustment and Reinstatement (answer Questions 3 - 8)     Non-Underwritten (answer Questions 3 - 4)

## 3. Description of Policy(s) After Adjustment

**a. Disability Income** Policy Number \_\_\_\_\_

Monthly Benefit Amount: \$ \_\_\_\_\_

Elimination Period:     30 day     60 day     90 day     180 day     365 day  
 Benefit Period:         2 year     5 year     to age 65     to age 67     to age 70  
 Your Occupation Period:  2 year     5 year     to age 65     to age 67     to age 70

Social Insurance Substitute (SIS) Monthly Benefit: \$ \_\_\_\_\_ SIS Benefit Period must equal Base Benefit Period.  
 SIS Elimination Period:  30 day     60 day     90 day     180 day     365 day

Adaptable Income Benefits (AIB) **Note: AIBs program monthly benefits around other in-force coverage**  
 1st AIB Monthly Benefit: \$ \_\_\_\_\_ from day \_\_\_\_\_ to day \_\_\_\_\_  
 2nd AIB Monthly Benefit: \$ \_\_\_\_\_ from day \_\_\_\_\_ to day \_\_\_\_\_  
 SIS AIB Monthly Benefit: \$ \_\_\_\_\_ from day \_\_\_\_\_ to day \_\_\_\_\_

**Other Benefit Riders** (Please note: All benefit riders are **not** available for all policy series. Refer to the adjustment illustration for availability.)                       **I request no change to existing policy riders in force.**

<u>Add</u>	<u>Delete</u>	<u>Change</u>	<u>Benefit Rider</u>
<input type="checkbox"/>	<input type="checkbox"/>		Automatic Benefit Increase
<input type="checkbox"/>	<input type="checkbox"/>		Automatic Increase Option
<input type="checkbox"/>	<input type="checkbox"/>		Benefit Update
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Catastrophic Disability Benefit (CDB)\$ _____ (total monthly amount) CDB Elimination Period: <input type="checkbox"/> 90 day <input type="checkbox"/> 180 day <input type="checkbox"/> 365 day CDB Benefit Period: <input type="checkbox"/> 2 year <input type="checkbox"/> 5 year <input type="checkbox"/> to age 65 <input type="checkbox"/> to age 67 <input type="checkbox"/> to age 70
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cost of Living Adjustment _____ %
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Extended Total Disability Benefit: <input type="checkbox"/> 50 <input type="checkbox"/> 75 <input type="checkbox"/> 100
<input type="checkbox"/>	<input type="checkbox"/>		Future Benefit Increase
<input type="checkbox"/>	<input type="checkbox"/>		Partial Disability Benefit
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Recovery Benefit: <input type="checkbox"/> 1 year <input type="checkbox"/> 3 year
<input type="checkbox"/>	<input type="checkbox"/>		Regular Occupation
<input type="checkbox"/>	<input type="checkbox"/>		Residual Disability Benefit
<input type="checkbox"/>	<input type="checkbox"/>		Return to Work
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Short Term Residual Disability Benefit: <input type="checkbox"/> 6 month <input type="checkbox"/> 12 month
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Transitional Occupation: <input type="checkbox"/> 2 year <input type="checkbox"/> 5 year <input type="checkbox"/> to age 65 <input type="checkbox"/> to age 67 <input type="checkbox"/> to age 70
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other _____



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# Disability Insurance Adjustment or Reinstatement Application - PART A

Proposed Insured \_\_\_\_\_

**b. Overhead Expense** – Complete Overhead Expense App Supplement **Policy Number** \_\_\_\_\_  
 Benefit Amount \$ \_\_\_\_\_ Elimination Period \_\_\_\_\_ Maximum Aggregate Benefit Factor \_\_\_\_\_

**Other Benefit Riders**

<u>Add</u>	<u>Delete</u>	<u>Benefit</u>	<u>Add</u>	<u>Delete</u>	<u>Benefit</u>
<input type="checkbox"/>	<input type="checkbox"/>	Automatic Benefit Increase	<input type="checkbox"/>	<input type="checkbox"/>	Benefit Update
<input type="checkbox"/>	<input type="checkbox"/>	Automatic Increase Option	<input type="checkbox"/>	<input type="checkbox"/>	Residual Disability

**c. Disability Buy-Out** – Complete Disability Buy-Out App Supplement **Policy Number** \_\_\_\_\_  
 Elimination Period \_\_\_\_\_ Lump Sum \$ \_\_\_\_\_ and/or Monthly \$ \_\_\_\_\_ Benefit Period \_\_\_\_\_

**Other Benefit Riders**

<u>Add</u>	<u>Delete</u>	<u>Benefit</u>
<input type="checkbox"/>	<input type="checkbox"/>	Employment in the Firm
<input type="checkbox"/>	<input type="checkbox"/>	Benefit Update

**d. DI Retirement Security** – Complete DI Retirement Security App Supplement **Policy Number** \_\_\_\_\_

**Other Benefit Riders**

<u>Add</u>	<u>Delete</u>	<u>Benefit</u>			
<input type="checkbox"/>	<input type="checkbox"/>	Future Benefit Increase			
<input type="checkbox"/>	<input type="checkbox"/>	Cost of Living Adjustment	<input type="checkbox"/> 3% max	<input type="checkbox"/> 6% max	
	<input type="checkbox"/>	Automatic Increase Option			

## 4. Brief Description of Adjustment, Reinstatement, or Special Instructions

\_\_\_\_\_  
 \_\_\_\_\_

## 5. Other Disability Insurance

Do you have, are you applying for, or will you become eligible for in the next three years (based on a qualifying period of employment), any other Disability Insurance? .....  Yes  No

If Yes, please list below any Disability Income (listing any Catastrophic or Lifetime Benefits separately), Group Disability, Association, State Disability, Retirement/Pension, Overhead Expense, Disability Buy-Out, Key-person, Salary Continuation or Short Term Contingency Disability Insurance. Also include any policies that include disability benefits provided under Accident or Sickness insurance, Pension, Retirement, or Credit Insurance plans.

Company	Policy No.	Type of Coverage	Benefit Amt. or % of Income	Elim. Period	Benefit Period	Ind. Pay (I) Emp. Pay (E)		Pending		Replacing	
						<input type="checkbox"/>	<input type="checkbox"/>	Yes	No	Yes	No
						<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
						<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
						<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
						<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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



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## Disability Insurance Adjustment or Reinstatement Application - PART A

Proposed Insured \_\_\_\_\_ Policy Number (if known) \_\_\_\_\_

### 6. Premium Payer

- a. Premium paid by:     Proposed Insured \_\_\_\_ %         Employer \_\_\_\_ %
- b. If your employer pays any part of the premium, is it reportable by you as taxable income? .....  Yes     No

### 7. Financial

- a. **Unearned Income** – Includes capital gains, interest, dividends, net rental income, pensions, annuities, and alimony. Is unearned income greater than 10% of earned income, or \$30,000?.....  Yes     No  
 If Yes, itemize: \_\_\_\_\_
- b. **Net Worth** – Is net worth, excluding primary residence, greater than \$6,000,000? .....  Yes     No  
 If Yes, itemize: \_\_\_\_\_

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

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

### 8. Medical Question

- a. Within the last five years, have you been treated for, or diagnosed as having a heart condition, chest pain, stroke, back or neck problem, psychological condition (including, but not limited to, counseling from a mental health or substance abuse provider, and/or psychotherapy), cancer, diabetes, alcohol abuse, or drug dependency?.....  Yes     No  
 If Yes, provide details in the Comments below, including dates and healthcare provider's name and address.
- b. Current Height \_\_\_\_\_ Weight \_\_\_\_\_ Have you lost more than 10 lbs. in the last year? .....  Yes     No
- c. Are you actively working in your occupation at least 30 hours per week? .....  Yes     No

Comments: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

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



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## Disability Insurance Adjustment or Reinstatement Application – PART C

Proposed Insured \_\_\_\_\_ Policy Number (if known) \_\_\_\_\_

**Agreement/Authorization to Obtain and Disclose Information.**

("Company" means Principal Life Insurance Company)

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

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

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

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

If preapproved by Principal Life Insurance Company:

I have signed, dated and submitted to the Company one of the three documents listed below in this box. I have been given the Conditional Receipt. In return I have read, understand, and agree to its terms.

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

**For Reinstatements Only: When Insurance Effective:** I understand and agree that the Company shall incur no liability unless: (1) a policy reinstated on this application(s) has been received and accepted by the owner and three month's premium is paid; and, (2) at the time of such receipt and payment, the person to be insured is actually in the state of health and insurability represented in this application(s), medical questionnaire(s), or amendment(s) that becomes a part of this application(s); and (3) the Part D of the completed Tele-App interview or the Delivery Receipt form is signed by me and the Insured (if different) and dated at delivery. If these conditions are met, the reinstatement is deemed effective on the date of approval. Also, if the Company has not already declined the reinstatement in writing, the reinstatement will become effective on the 45<sup>th</sup> day after the date of the Conditional Receipt.

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

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

If preapproved by Principal Life Insurance Company:

I have signed, dated and submitted to the Company one of the three documents listed below in this box. I have been given the Conditional Receipt. In return I have read, understand, and agree to its terms.

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

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

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## Disability Insurance Adjustment or Reinstatement Application – PART C

Proposed Insured \_\_\_\_\_ Policy Number (if known) \_\_\_\_\_

(continued from previous page)

### PART C – Agreement/Authorization to Obtain and Disclose Information

**AUTHORIZATION:** I authorize any insurance (or reinsuring) company, consumer reporting agency, governmental agency, licensed insurance agent, broker, or representative, or any other organization, institution, or person having personal information (including physical, mental, drug, or alcohol use history) regarding the named Proposed Insured to provide to the Company, its representatives, or reinsurers, any such data. I authorize the Company to conduct a telephone interview in connection with my application(s) for insurance.

I authorize the Medical Information Bureau, Inc. (MIB, Inc.) to furnish data to the Company or its reinsurers. I authorize Principal Life to release any such data to MIB, Inc. or as required by law. Notwithstanding any other provision in this form, the authorization to release data to the MIB, Inc. shall survive the termination of this form to the extent necessary to confirm, correct, or update previously supplied data to the MIB, Inc. Data released may include results of my medical examination or tests requested by the Company. I understand that the data obtained by use of this authorization will be used by the Company to determine eligibility for insurance.

I have received a copy of the “Notice of Insurance Information Practices,” which includes notice required by any Fair Credit Reporting Act. It also describes MIB, Inc. I agree that this authorization shall be valid for 24 months from the earlier of: (1) the date of this application(s), or (2) the date of my policy. I may revoke this authorization for information not then obtained. Such revocation must be in writing. It will not be effective until received at the Company’s Home Office. I agree that a photocopy of this authorization is as valid as the original. I have received a copy of this authorization.

**Pre-Existing Condition Limitation:** The policy being adjusted or reinstated does not cover Disability or loss which begins within two years after the effective date of coverage(s) and results from a pre-existing condition which occurred within the two year period prior to the effective date of coverage(s) and was not disclosed or was misrepresented in this application.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

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

Proposed Insured ( <i>Signature</i> ) <b>X</b>	Signed at: City	State	Date / /
Disability Income; Owner (If other than Proposed Insured) <b>X</b>	Title (If Corporation, Officer other than Proposed Insured)		Date / /
Overhead Expense; Owner (If other than Proposed Insured) <b>X</b>	Title (If Corporation, Officer other than Proposed Insured)		Date / /
Disability Buy-Out; Owner <b>X</b>	Title (If Corporation, Officer other than Proposed Insured)		Date / /
Licensed Agent/Broker/Representative ( <i>Signature</i> ) <b>X</b>	License Number		Date / /
Co-signature by Resident Licensed Rep. (If applicable in your state) <b>X</b>	License Number		Date / /



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## Disability Insurance Adjustment or Reinstatement Application – PART C

Proposed Insured \_\_\_\_\_ Policy Number (if known) \_\_\_\_\_

### Agreement/Authorization to Obtain and Disclose Information.

("Company" means Principal Life Insurance Company)

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

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

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

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

If preapproved by Principal Life Insurance Company:

I have signed, dated and submitted to the Company one of the three documents listed below in this box. I have been given the Conditional Receipt. In return I have read, understand, and agree to its terms.

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

**For Reinstatements Only: When Insurance Effective:** I understand and agree that the Company shall incur no liability unless: (1) a policy reinstated on this application(s) has been received and accepted by the owner and three month's premium is paid; and, (2) at the time of such receipt and payment, the person to be insured is actually in the state of health and insurability represented in this application(s), medical questionnaire(s), or amendment(s) that becomes a part of this application(s); and (3) the Part D of the completed Tele-App interview or the Delivery Receipt form is signed by me and the Insured (if different) and dated at delivery. If these conditions are met, the reinstatement is deemed effective on the date of approval. Also, if the Company has not already declined the reinstatement in writing, the reinstatement will become effective on the 45<sup>th</sup> day after the date of the Conditional Receipt.

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

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

If preapproved by Principal Life Insurance Company:

I have signed, dated and submitted to the Company one of the three documents listed below in this box. I have been given the Conditional Receipt. In return I have read, understand, and agree to its terms.

- Payroll Deduction Authorization Form
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## Disability Insurance Adjustment or Reinstatement Application – PART C

Proposed Insured \_\_\_\_\_ Policy Number (if known) \_\_\_\_\_

(continued from previous page)

### Agreement/Authorization to Obtain and Disclose Information

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

**AUTHORIZATION:** I authorize any insurance (or reinsuring) company, consumer reporting agency, governmental agency, licensed insurance agent, broker, or representative, or any other organization, institution, or person having personal information (including physical, mental, drug, or alcohol use history) regarding the named Proposed Insured to provide to the Company, its representatives, or reinsurers, any such data. I authorize the Company to conduct a telephone interview in connection with my application(s) for insurance.

I authorize the Medical Information Bureau, Inc. (MIB, Inc.) to furnish data to the Company or its reinsurers. I authorize Principal Life to release any such data to MIB, Inc. or as required by law. Notwithstanding any other provision in this form, the authorization to release data to the MIB, Inc. shall survive the termination of this form to the extent necessary to confirm, correct, or update previously supplied data to the MIB, Inc. Data released may include results of my medical examination or tests requested by the Company. I understand that the data obtained by use of this authorization will be used by the Company to determine eligibility for insurance.

I have received a copy of the "Notice of Insurance Information Practices," which includes notice required by any Fair Credit Reporting Act. It also describes MIB, Inc. I agree that this authorization shall be valid for 24 months from the earlier of: (1) the date of this application(s), or (2) the date of my policy. I may revoke this authorization for information not then obtained. Such revocation must be in writing. It will not be effective until received at the Company's Home Office. I agree that a photocopy of this authorization is as valid as the original. I have received a copy of this authorization.

**Pre-Existing Condition Limitation:** The policy being adjusted or reinstated does not cover Disability or loss which begins within two years after the effective date of coverage(s) and results from a pre-existing condition which occurred within the two year period prior to the effective date of coverage(s) and was not disclosed or was misrepresented in this application.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.



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

## Disability Insurance Adjustment or Reinstatement Conditional Receipt

**(In this Conditional Receipt (Receipt), "we", "us", "our", or "the Company" is Principal Life Insurance Company.)**

Name of Proposed Insured \_\_\_\_\_

Advance payment of: (Disability Income)	(Overhead Expense)	(Disability Buy-Out)
\$ _____	\$ _____	\$ _____

has been received this date as a premium deposit with the application(s) bearing the same date as this Receipt.

Licensed Agent/Broker/Representative _____	Date of Receipt _____ / _____ / _____
--	---------------------------------------

**Authority:**

**This Receipt does not create any temporary or interim insurance. However, it does set the date when the insurance under the policy applied for will become effective if all required conditions are met. No licensed agent, broker, or representative, medical examiner, or telephone interviewer may accept risks, determine insurability, or bind the Company in any way. No licensed agent, broker, or 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 licensed agent, broker, or representative has **NO AUTHORITY** to accept any premium or to issue this Receipt: 1) if it is apparent that any **Condition Precedent** to coverage under this Receipt is not or cannot be satisfied; 2) for removal of any extra premium or exclusion rider. **This Conditional Receipt shall be ineffective if issued without authority. Only the Home Office, and not the licensed agent, broker, or representative, has authority to modify any provisions of this Receipt.**

**Insurance Provided:**

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

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

The Stop Date for adjustments is the earliest of:

- (a) 75 days after the Start Date;
- (b) the date we mail the premium payer a premium refund and a notice that we will not consider the application(s) on a prepaid basis;
- (c) the date we mail the premium payer a premium refund and a notice that no adjustment will be issued on the application(s);
- (d) the date an approved adjustment is presented to the owner (whether or not accepted by the owner).

The Stop Date for reinstatements is the earliest of:

- (a) 45 days after the application(s) date;
- (b) the date we mail the premium payer a premium refund and a notice that no reinstatement will be approved on the application(s);
- (c) the date the policy(ies) is reinstated.

In determining whether to issue coverage and on what terms, we will consider no changes in the Insured's health or insurability occurring between the Start Date and Stop Date. If any provision of this Receipt is unenforceable under state law, all other terms and conditions shall continue in full force and effect.

**--CONTINUED--**

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

**All of the following conditions must be fulfilled exactly before any insurance becomes effective. Otherwise there is NO insurance under the terms of the policy and the Receipt is void:**

1. All statements of material fact are included in Part(s) A, B, and C of this application(s), any supplemental form(s) and medical questionnaire(s) that become part of the policy(ies) and such statements are correct, true, and complete to the best of your knowledge and belief.
2. The premium deposit must be paid at the time the application(s) is signed, and this Receipt must be issued at the same time.
3. The premium deposit must be received in our Home Office and must be honored on first presentation for payment.
4. The premium deposit for adjustments must be at least one full month's premium for each adjustment applied for. The premium deposit for reinstatements must be at least three month's premium for each reinstatement applied for.
5. The insured must be insurable on the Start Date. If a condition affecting such insurability existed in fact on the Start Date, it shall be considered in the determination of insurability.
  - a. For an adjustment, "Insurable" means insurable under our underwriting guidelines and standards in effect as of the date of the adjustment application(s), and:
    - (i) the policy(ies) must be in force as of the date of this receipt, and
    - (ii) the amounts and benefits applied for can be provided at our standard premium rate with no restrictive riders; or
    - (iii) the amounts, benefits and premium can be provided but on a modified basis which may include restrictive riders and/or premium ratings.
  - b. For a reinstatement, "Insurable" means insurable under our underwriting guidelines and standards in effect as of the date of the reinstatement application(s), and:
    - (i) the amounts and benefits of the policy(ies) can be reinstated without addition of restrictive riders and/or premium ratings, and
    - (ii) the insured must be insurable for disability insurance based on the terms of the lapsed policy(ies) on the Start Date.

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

**All of the following conditions must be fulfilled exactly before any insurance becomes effective. Otherwise there is NO insurance under the terms of the policy and the Receipt is void:**

1. All statements of material fact are included in Part(s) A, B, and C of this application(s), any supplemental form(s) and medical questionnaire(s) that become part of the policy(ies) and such statements are correct, true, and complete to the best of your knowledge and belief.
2. Documentation authorizing payment of premiums, which is acceptable to the Company, must be signed, dated, submitted with the application(s), and this Receipt must be issued at the same time.
3. Documentation authorizing payment of premiums, which is acceptable to the Company, must be received in our Home Office.
4. The insured must be insurable on the Start Date. If a condition affecting such insurability existed in fact on the Start Date, it shall be considered in the determination of insurability.
  - a. For an adjustment, "Insurable" means insurable under our underwriting guidelines and standards in effect as of the date of the adjustment application(s), and:
    - (i) the policy(ies) must be in force as of the date of this receipt, and
    - (ii) the amounts and benefits applied for can be provided at our standard premium rate with no restrictive riders; or
    - (iii) the amounts, benefits and premium can be provided but on a modified basis which may include restrictive riders and/or premium ratings.
  - b. For a reinstatement, "Insurable" means insurable under our underwriting guidelines and standards in effect as of the date of the reinstatement application(s), and:
    - (i) the amounts and benefits of the policy(ies) can be reinstated without addition of restrictive riders and/or premium ratings, and
    - (ii) the insured must be insurable for disability insurance based on the terms of the lapsed policy(ies) on the Start Date.

--CONTINUED--

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**Limitations:**

1. Except as limited by this Receipt, our liability is governed by the terms of the policy(ies), including but not limited to all policy(ies) riders and endorsements.
2. No benefit is payable under the terms of the policy and this Receipt is void, if there is any incorrect, untrue, incomplete, or omitted statement of material fact in Part A, B, or C of the application(s), any supplemental form, or medical questionnaire(s) that becomes a part of the policy(ies). Subject to the Time Limit on Certain Defenses provision in the policy, no knowledge of any fact on the part of any licensed agent, broker, or representative, medical examiner, telephone interviewer, or other person shall be considered knowledge of the Company unless such fact is stated in the application(s).
3. There is NO coverage under the terms of the policy before the Start Date.
4. There is NO coverage under the terms of the policy after the Stop Date.
5. There is NO coverage under the terms of the policy if any material misrepresentation exists on the application(s) or examination.
6. There is NO coverage under the terms of the policy for adjustments if less than a full month's premium is paid. There is NO coverage under the terms of the policy for reinstatements if less than three month's premium is paid.
7. a. For an adjustment, limits of coverage under the terms of the policy are the lesser of:
  - (i) the amount of insurance applied for, or
  - (ii) the modified insurance as determined by 4a(iii) above, or
  - (iii) \$5,000 per month (Disability Benefit and Social Insurance Substitute Benefit); \$5,000 per month (Overhead Expense Benefit); \$2,500 per month (Catastrophic Disability Benefit); \$500,000 (Disability Buy-Out Maximum Aggregate Benefit).
- b. For a reinstatement, limits of coverage under the terms of the policy are the lesser of:
  - (i) the amount of the lapsed policy(ies), or
  - (ii) \$5,000 per month (Disability Benefit and Social Insurance Substitute Benefit); \$5,000 per month (Overhead Expense Benefit); \$2,500 per month (Catastrophic Disability Benefit); \$500,000 (Disability Buy-Out Maximum Aggregate Benefit).

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**Premiums:**

If no adjustment is put in force and no benefit is paid or if an adjustment is issued differently than applied for that results in a premium refund, the premium sent with this adjustment application(s) or express premium will be refunded to the premium payer.

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



Mailing Address:  
Des Moines, IA 50392-0001

**Principal Life  
Insurance Company**

***Disclosure of  
Compensation Information***

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

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



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

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

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

(Applicable to Individual  
 Life and Disability  
 Insurance Customers)

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

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

Name of Proposed Insured/Patient (please print)

Date of Birth

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

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

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

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

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

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

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

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

Signature of Proposed Insured/Patient or Personal Representative

Date

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

DD 6000 UND-2



**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)

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**CLIENT COPY**

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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.

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

Signature of Proposed Insured/Patient or Personal Representative

Date

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

DD 6000 UND-2



### **Information Form For Insurance Proposed Insured**

Before consenting to testing, please read the following information:

To evaluate your insurability, the insurer named above (the Insurer) has requested that you provide a sample of your blood and/or oral fluids for testing and analysis. 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 on your sample 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 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. If your test result is positive, you may wish to consider further independent testing at your own cost.



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Before consenting to testing, please read the following information:

To evaluate your insurability, the insurer named above (the Insurer) has requested that you provide a sample of your blood and/or oral fluids for testing and analysis. 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 on your sample by a licensed laboratory through a medically accepted procedure.

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- 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. If your test result is positive, you may wish to consider further independent testing at your own cost.

**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.

**Further Information:**

For further information about AIDS, the meaning of HIV-related test results and the availability and location for HIV related counseling services, please call the Department of Health's state-wide toll-free number: 1-800-541-AIDS.

**Consent:**

I have read this Notice and Consent and I voluntarily consent to the withdrawal of blood from me, the testing of that blood, and the disclosure of the test results as described above.

\_\_\_\_\_  
Name of physician for reporting a possible positive result

\_\_\_\_\_  
Address | City | State | ZIP

There is also a form inside the blood profile 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** \_\_\_\_\_ **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**  
P.O. Box 14455  
Des Moines, IA 50306-3455

**Disability Insurance  
Notice of Insurance Information Practices**

We appreciate you applying for insurance with our company.

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

#### **Overview**

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

#### **Sources and Types of Information**

You are the primary source of personal data. We may call you to verify data on your application, or to obtain more data. We may ask you about your age, medical history, occupation, income, habits, hobbies and other personal characteristics. We may contact other sources for personal data, including: (1) spouse, (2) accountant, (3) lawyer, (4) employer, (5) other persons who know you well, (6) insurance companies to which you may have applied for insurance in the past, (7) MIB, Inc., (8) governmental agencies and (9) consumer reporting agencies. We may also contact your doctor, hospital or other health care provider to clarify your medical history. We may ask that you have medical exams and tests.

Proper underwriting of your application may require use of an investigative consumer report. Upon written request, we will tell you if a report is made. We will provide the name and address of any outside agency who prepares the report. We will also tell you the nature and substance of the report. It would contain the same types of information that we collect from the other sources listed above. This data may be obtained through interviews with you, your family, friends, neighbors and associates.

You may ask that you be interviewed if we request this report. Data collected and retained by a consumer reporting agency may be disclosed to other insurance companies having proper authorization.

#### **Our Use of Information**

We follow strict standards to safeguard your personal information. It will be seen only by employees and agents of Principal Life Insurance Company who underwrite and administer your coverage. We may also provide data to: (1) MIB, Inc.; (2) other insurance companies, if you authorize release of the data to them; (3) our reinsurers, if needed to secure reinsurance; (4) federal and state agencies, and others if required by law; (5) our research personnel (anonymously) to help market our products.

#### **Access To Your Data**

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

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

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

#### **MIB Pre-Notice**

Information regarding your insurability will be treated as confidential. Principal Life Insurance Company or its reinsurers may, however, make a brief report thereon to the MIB, Inc., formerly known as Medical Information Bureau, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is {50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734}.

Principal Life Insurance Company, or its reinsurers, may also release information in its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at [www.mib.com](http://www.mib.com).

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