Principal

Principal Life Insurance Company
P.O. Box 14455, Des Moines, IA 50306-3455
Member of Principal Financial Group®

Individual Disability Insurance Application
Part A

Applying for:	**Type of Coverage:**
☐ **New Application**	☐ **Disability Income**
☐ **Existing Policy Change/Reinstatement**	☐ **DI Retirement Security**
Policy Number _____	

▶ PROPOSED INSURED PERSONAL INFORMATION

Name (First, Middle, Last, Suffix) _____

Gender ☐ Male ☐ Female | Birth Date (mm/dd/yyyy) _____

Social Security Number _____ | Birth State/Country_____

Drivers License Number / Issued State_____

Primary Residence Street Address (Cannot be P.O. Box)_____

City_____ State_____ Zip_____

Phone Number_____

Email Address _____

Are you a U.S. Citizen or a permanent resident with a Green Card? ☐ Yes ☐ No
If no, a Confidential Non-US Citizen Questionnaire is required with this application.

Is English your primary language? ☐ Yes ☐ No *If no, a Statement of English Understanding form is required with this application.*

In the past 12 months have you used any tobacco or nicotine products? ☐ Yes ☐ No
Tobacco or nicotine products includes: cigarettes, pipe, cigars, chewing tobacco/snuff, hookah, e-cigarettes, vape or nicotine patch/gum

▶ PREMIUM RESPONSIBILITY INFORMATION

Is any portion of policy premium paid for by your employer or a business you own? ☐ Yes ☐ No
If yes, what percentage _____% and will the premium be included as taxable income to you ☐ Yes ☐ No

▶ PREMIUM PAYMENT METHOD/FREQUENCY

Indicate preferred method and frequency for premium payments. *You may skip this section if your employer is paying for this coverage.*

Electronic Fund Transfer (EFT)	Check
☐ Annual	☐ Annual
☐ Semi-Annual	☐ Semi Annual
☐ Quarterly	☐ Quarterly
☐ Monthly	

If preferred payment method is EFT, Payment Authorization for Electronic Fund Transfer form is required.

▶ EMPLOYMENT/FINANCIAL INFORMATION

Occupation /Title /Duties _____	
Is your unearned income greater than 20% of your earned income? ☐ Yes ☐ No *If yes:* What is the source of your unearned income _____ What is your total unearned income $_____	Is your net worth, excluding primary residence, greater than $10,000,000 ☐ Yes ☐ No *If yes:* What is your total net worth $_____

Non-owner employee

Current year annual earned income, as shown on your federal income tax return including commission bonus $_____	Prior year annual earned income, as shown on your federal income tax return, including commission bonus $_____	Two years ago annual earned income, as shown on your federal income tax return, including commission, bonus $_____

Business owners and 1099 contractors

Current year annual earned income, as shown on your federal income tax return including share of business profit/loss in addition to wages $_____	Prior year annual earned income, as shown on your federal income tax return including share of business profit/loss in addition to wages $_____	Two years ago annual earned income, as shown on your federal income tax return including share of business profit/loss in addition to wages $_____

Pension plan or profit-sharing contributions made on your behalf, by a business you own $_____

▶ COVERAGE APPLYING FOR OR REQUESTING TO CHANGE/REINSTATE

Existing policies – mark the applicable change/reinstatement requesting and provide additional details in description of changes section below

☐ **Disability Income**

Benefits *(not all features and riders are available in all states)*

Monthly benefit amount	$_____
Elimination Period	☐ 60 day ☐ 90 day ☐ 180 day ☐ 365 day
Benefit Period	☐ 2 year ☐ 5 year ☐ to Age 65 ☐ to Age 67 ☐ to Age 70
True Own Occupation Definition of Disability	☐ Total disability while not working in your own occupation
Riders	
Annual Increase	☐
Annual Increase and Maximize Your Benefits	☐ *(Annual Increase rider is required with Maximize Your Benefits rider)*
Capital Sum Benefit	☐
Catastrophic Disability Benefit	$_____
Cost of Living Adjustment	☐ 3% ☐ 6%
Death Benefit	☐
Mental Nervous and Substance Abuse Limitation	☐ *(required in some states and for certain occupations, not available in VT)*
Residual coverage options *(choose one)*	☐ Residual Disability & Recovery Benefit ☐ Short Term Residual Disability Benefit ☐ 6 months or ☐ 12 months
Supplemental Health Benefit	☐

Additional coverage options available on next page

☐ **DI Retirement Security**

Benefits *(not all features and riders are available in all states)*

Monthly benefit amount	$_____
Elimination Period	☐ 180 day ☐ 365 day
Benefit Period	☐ to age 65 ☐ to age 67
Riders	
Annual Increase	☐
Cost of Living Adjustment	☐ 3% ☐ 6%
Mental Nervous and Substance Abuse Limitation	☐ *(required in some states and for certain occupations, not available in VT)*
A completed Declaration of Trust form required with this application.	

▶ OTHER COVERAGE

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, provide details for each in-force or pending disability insurance policy, including Individual Disability Insurance, Group Long-Term Disability, coverage through an Association, disability buy-out, overhead expense, key person insurance or loan protection coverage. If coverage is being changed or reduced, indicate details including amount, below.

Company	Type of Coverage	Benefit Amount / % of Income	Maximum Benefit Amount	Premium Payor		To Be Replaced or Changed?			Application Pending?	
				Self	Employer	Replace	Change	No	Yes	No
				☐	☐	☐	☐	☐	☐	☐
				☐	☐	☐	☐	☐	☐	☐
				☐	☐	☐	☐	☐	☐	☐
				☐	☐	☐	☐	☐	☐	☐

Details (indicate policy change/reduction details):_____

Replacing/Changing Coverage: *By signing Part C of this application, the Proposed Insured agrees to terminate or reduce the insurance policy(s) indicated above within 60 days of the acceptance of this policy. Signing indicates the Proposed Insured understands that by not canceling or reducing the other coverage, Principal Life Insurance Company has the right to rescind (terminate as if never issued) any policy issued from this application.*

▶ POLICY OWNER *(complete if Policy Owner and Proposed Insured are different)*

Coverage applicable to Policy Owner ☐ Disability Income ☐ DI Retirement Security

Individual Owner Name (First, Middle, Last, Suffix)			**Organization Owner Name** (Full legal name)		
Social Security Number	Birth Date (mm/dd/yyyy)		Employer Identification Number		
Primary Residence Street Address (Cannot be P.O. Box)			**Primary** Headquarters Street Address (Cannot be P.O. Box)		
City	State	Zip	City	State	Zip
Phone Number			Phone Number		
Email Address			Company Rep. Email Address		
Relationship to Proposed Insured: ☐ Spouse ☐ Parent ☐ Sibling ☐ Domestic Partner ☐ Business Partner			Relationship to Proposed Insured: ☐ Employer ☐ Owner of Organization		

To assign benefits to an Individual or Organization which is not the Proposed Insured nor the Policy Owner, submit an Assignment of Policy Benefit form.

▶ POLICY CHANGE / REINSTATEMENT: DESCRIPTION OF CHANGES

Principal Life Insurance Company
P.O. Box 14455, Des Moines, IA 50306-3455
Member of Principal Financial Group®

Individual Disability Insurance Application
Part C

Proposed Insured _____

Agreement/Authorization to Obtain and Disclose Information.

("Company" means Principal Life Insurance Company)

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

When Coverage Becomes Effective: I understand and agree that the Company shall incur no liability until: (1) a policy issued on this application(s) has been received and accepted by the owner and the first premium paid; and (2) at the time of such delivery 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 Application or the Delivery Receipt form, and any required Amendment and Acceptance or other forms are signed by me and the Proposed Insured (if different) and dated at delivery. If these conditions are met, the policy is deemed effective on the Policy Date stated in the policy. If the application was submitted COD (cash on delivery) or a request for a change in the Policy date is received, the Policy Date may be changed to the date coverage becomes effective and a new Data Page will be sent to the Policy Owner.

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

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

☐ I have paid $ _____ for Disability Income
If money was paid, I have been given the Conditional Receipt. In return I have read, understand, and agree to its terms, or

If preapproved by Principal Life Insurance Company:
☐ I have signed, dated and submitted to the Company one of the three documents listed below in this box. I have been given the Conditional Receipt. In return I have read, understand, and agree to its terms.

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

(continued on next page)

Principal Life Insurance Company
P.O. Box 14455, Des Moines, IA 50306-3455
Member of Principal Financial Group®

Individual Disability Insurance Application
Part C

Proposed Insured _____

(continued from previous page)

Agreement/Authorization to Obtain and Disclose Information

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

I authorize MIB, LLC and any MIB member insurer, to provide any medical or personal information that it has about me to the Company, its reinsurer or any MIB-authorized third-party administrator performing underwriting services on the Company's behalf. I also authorize the Company, its reinsurer or authorized third-party administrator, to make a brief report of my medical or personal information to MIB, LLC. Notwithstanding any other provision in this form, the authorization to release data to the MIB, LLC shall survive the termination of this form to the extent necessary to confirm, correct, or update previously supplied data to the MIB, LLC. 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, LLC. 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, unless an earlier date is required by applicable law in the state where the policy is delivered or issued for delivery. I may revoke this authorization for information not then obtained. Such revocation must be in writing. It will not be effective until received at the Company's Home Office. I agree that a photocopy of this authorization is as valid as the original. I have received a copy of this authorization.

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

► SIGNATURES *(City, State, Date and printed name of Financial Professional are required)*

Signature of Proposed Insured **X**	Signed at: City	State	Date / /
Signature of Policy Owner (If other than Proposed Insured) **X**	Signed at: City	State	Date / /
Title (If Organization, Officer other than Proposed Insured):			
Signature of Financial Professional **X**	License Number		Date / /
Printed name of Financial Professional **X**			

Agreement/Authorization to Obtain and Disclose Information.

("Company" means Principal Life Insurance Company)

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

When Coverage Becomes Effective: I understand and agree that the Company shall incur no liability until: (1) a policy issued on this application(s) has been received and accepted by the owner and the first premium paid; and (2) at the time of such delivery 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 Application or the Delivery Receipt form, and any required Amendment and Acceptance or other forms are signed by me and the Proposed Insured (if different) and dated at delivery. If these conditions are met, the policy is deemed effective on the Policy Date stated in the policy. If the application was submitted COD (cash on delivery) or a request for a change in the Policy date is received, the Policy Date may be changed to the date coverage becomes effective and a new Data Page will be sent to the Policy Owner.

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

☐ I have paid $ _____ for Disability Income
If money was paid, I have been given the Conditional Receipt. In return I have read, understand, and agree to its terms, or

If preapproved by Principal Life Insurance Company:
☐ I have signed, dated and submitted to the Company one of the three documents listed below in this box. I have been given the Conditional Receipt. In return I have read, understand, and agree to its terms.

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

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

I authorize MIB, LLC and any MIB member insurer, to provide any medical or personal information that it has about me to the Company, its reinsurer or any MIB-authorized third-party administrator performing underwriting services on the Company's behalf. I also authorize the Company, its reinsurer or authorized third-party administrator, to make a brief report of my medical or personal information to MIB, LLC. Notwithstanding any other provision in this form, the authorization to release data to the MIB, LLC shall survive the termination of this form to the extent necessary to confirm, correct, or update previously supplied data to the MIB, LLC. 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, LLC. 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, unless an earlier date is required by applicable law in the state where the policy is delivered or issued for delivery. I may revoke this authorization for information not then obtained. Such revocation must be in writing. It will not be effective until received at the Company's Home Office. I agree that a photocopy of this authorization is as valid as the original. I have received a copy of this authorization.

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AGREEMENT/AUTHORIZATION – Give to Proposed Insured

Principal

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

Individual Life and Disability Insurance Application –
Part B

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

PROPOSED INSURED(S)

Name 1 (First, Middle, Last, Suffix)

Birth Date (mm/dd/yyyy)

Name 2 (First, Middle, Last, Suffix) **– For Survivorship Products only**

Birth Date (mm/dd/yyyy)

EMPLOYMENT / INCOME INFORMATION

Name 1	**Name 2**
1. What is your primary occupation?	1. What is your primary occupation?
2. Type of business or industry?	2. Type of business or industry?
3. What is the name of your employer?	3. What is the name of your employer?
4. Total number of employees at your company (excluding yourself)?	4. Total number of employees at your company (excluding yourself)?
5. How long have you been employed by your current employer? (If less than 2 years, provide details, e.g. employers, occupations and dates for past 5 years)	5. How long have you been employed by your current employer? (If less than 2 years, provide details, e.g. employers, occupations and dates for past 5 years)
6. How many hours do you work per week in your primary occupation?	6. How many hours do you work per week in your primary occupation?
7. What are your current job duties and percentage of time doing each? % % %	7. What are your current job duties and percentage of time doing each? % % %
8. Do you have any other part-time or full-time jobs? ☐ Yes ☐ No If Yes, explain:	8. Do you have any other part-time or full-time jobs? ☐ Yes ☐ No If Yes, explain:
9. For the past 180 days have you been continuously at work for your scheduled hours performing the duties of your occupation without an injury or sickness? ☐ Yes ☐ No If No, explain:	9. For the past 180 days have you been continuously at work for your scheduled hours performing the duties of your occupation without an injury or sickness? ☐ Yes ☐ No If No, explain:

PROPOSED INSURED(S)

Name 1 (First, Middle, Last, Suffix)

Birth Date (mm/dd/yyyy)

Name 2 (First, Middle, Last, Suffix) **– For Survivorship Products only**

Birth Date (mm/dd/yyyy)

EMPLOYMENT / INCOME INFORMATION (Continued)

10. Do you intend to change jobs or employment in the next 6 months? ☐ Yes ☐ No

If Yes, explain:

11. Do you have ownership in any employer you work for? ☐ Yes ☐ No

If Yes, provide ownership %, length of ownership, organization type, # of employees and # of hours per week worked at home:

12. What is your annual income from your primary occupation?

13. Do you have any additional income from any other source? ☐ Yes ☐ No

If Yes, explain:

14. What is your net worth (assets minus liabilities)?

10. Do you intend to change jobs or employment in the next 6 months? ☐ Yes ☐ No

If Yes, explain:

11. Do you have ownership in any employer you work for? ☐ Yes ☐ No

If Yes, provide ownership %, length of ownership, organization type, # of employees and # of hours per week worked at home:

12. What is your annual income from your primary occupation?

13. Do you have any additional income from any other source? ☐ Yes ☐ No

If Yes, explain:

14. What is your net worth (assets minus liabilities)?

PROPOSED INSURED(S)

Name 1 (First, Middle, Last, Suffix)

Birth Date (mm/dd/yyyy)

Name 2 (First, Middle, Last, Suffix) **– For Survivorship Products only**

Birth Date (mm/dd/yyyy)

PERSONAL INFORMATION

1. In the past 5 years, have you requested or received any type of disability benefits (including workers' compensation, military disability, or state disability) for an injury or illness?
   ☐ Yes ☐ No
   If Yes, explain:

2. Have you ever had any life, health, or disability insurance application declined, charged a higher premium (rated), or had coverage limited, or excluded (modified)?
   ☐ Yes ☐ No
   If Yes, explain:

3. In the past 10 years, have you or any business owned by you, been in bankruptcy or similar proceedings?
   ☐ Yes ☐ No
   If Yes, explain:

4. When was the last time you used tobacco or nicotine products?

Name 1	Current	Within the past 12 months	1-2 years ago	2-3 years ago	3-5 years ago	Over 5 years ago	Never
Cigarettes	☐	☐	☐	☐	☐	☐	☐
Cigars	☐	☐	☐	☐	☐	☐	☐
Chewing tobacco or snuff	☐	☐	☐	☐	☐	☐	☐
Nicotine gum or patch	☐	☐	☐	☐	☐	☐	☐
E-cigarette or vaping products	☐	☐	☐	☐	☐	☐	☐
Other	☐	☐	☐	☐	☐	☐	☐

If Other is selected, explain:

4. When was the last time you used tobacco or nicotine products?

Name 2	Current	Within the past 12 months	1-2 years ago	2-3 years ago	3-5 years ago	Over 5 years ago	Never
Cigarettes	☐	☐	☐	☐	☐	☐	☐
Cigars	☐	☐	☐	☐	☐	☐	☐
Chewing tobacco or snuff	☐	☐	☐	☐	☐	☐	☐
Nicotine gum or patch	☐	☐	☐	☐	☐	☐	☐
E-cigarette or vaping products	☐	☐	☐	☐	☐	☐	☐
Other	☐	☐	☐	☐	☐	☐	☐

If Other is selected, explain:

PROPOSED INSURED(S)

Name 1 (First, Middle, Last, Suffix)

Birth Date (mm/dd/yyyy)

Name 2 (First, Middle, Last, Suffix) **– For Survivorship Products only**

Birth Date (mm/dd/yyyy)

PERSONAL INFORMATION (Continued)

Name 1

5. How many alcoholic beverages do you drink per week?

- ☐ None
- ☐ 1-7
- ☐ 8-14
- ☐ 15-21
- ☐ 22-28
- ☐ 29-35
- ☐ 36-42
- ☐ 43 or more
- ☐ Temporarily not drinking (pregnancy, nursing, training)
- ☐ Special Occasions
- ☐ No longer drinking
- ☐ I've never drank

6. IN THE PAST 10 YEARS HAVE YOU:

a) used any of the following types of marijuana or any products containing THC? (check all that apply)

- ☐ CBD Product(s)
- ☐ Edibles
- ☐ Other (please explain)
- ☐ Smoked Marijuana
- ☐ Vaping

If Other selected, explain:

☐ I have not used marijuana or THC products in the past 10 years

b) used cocaine, opioids, methamphetamines, or any other controlled substances not prescribed by a physician? ☐ Yes ☐ No

If Yes, explain:

c) sought or received counseling or medical treatment for alcohol or drug use from a member of the medical profession, or participated in a support group for alcohol or drug use? ☐ Yes ☐ No

If Yes, explain:

d) been advised to limit or discontinue alcohol or drug use by a medical professional? ☐ Yes ☐ No

If Yes, explain:

e) pled guilty to or been convicted of a felony or misdemeanor? ☐ Yes ☐ No

If Yes, explain:

f) been a member of the military, military reserve or National Guard, or have you entered into a written agreement to become one in the future? ☐ Yes ☐ No

If Yes, explain:

Name 2

5. How many alcoholic beverages do you drink per week?

- ☐ None
- ☐ 1-7
- ☐ 8-14
- ☐ 15-21
- ☐ 22-28
- ☐ 29-35
- ☐ 36-42
- ☐ 43 or more
- ☐ Temporarily not drinking (pregnancy, nursing, training)
- ☐ Special Occasions
- ☐ No longer drinking
- ☐ I've never drank

6. IN THE PAST 10 YEARS HAVE YOU:

a) used any of the following types of marijuana or any products containing THC? (check all that apply)

- ☐ CBD Product(s)
- ☐ Edibles
- ☐ Other (please explain)
- ☐ Smoked Marijuana
- ☐ Vaping

If Other selected, explain:

☐ I have not used marijuana or THC products in the past 10 years

b) used cocaine, opioids, methamphetamines, or any other controlled substances not prescribed by a physician? ☐ Yes ☐ No

If Yes, explain:

c) sought or received counseling or medical treatment for alcohol or drug use from a member of the medical profession, or participated in a support group for alcohol or drug use? ☐ Yes ☐ No

If Yes, explain:

d) been advised to limit or discontinue alcohol or drug use by a medical professional? ☐ Yes ☐ No

If Yes, explain:

e) pled guilty to or been convicted of a felony or misdemeanor? ☐ Yes ☐ No

If Yes, explain:

f) been a member of the military, military reserve or National Guard, or have you entered into a written agreement to become one in the future? ☐ Yes ☐ No

If Yes, explain:

PROPOSED INSURED(S)

Name 1 (First, Middle, Last, Suffix)

Birth Date (mm/dd/yyyy)

Name 2 (First, Middle, Last, Suffix) **– For Survivorship Products only**

Birth Date (mm/dd/yyyy)

PERSONAL INFORMATION (Continued)

Name 1

7. In the past 2 years, have you lived outside the United States? ☐ Yes ☐ No
   If Yes, explain:
8. In the next 2 years, do you have plans to live outside the United States? ☐ Yes ☐ No
   If Yes, explain:
9. In the past 2 years, have you traveled outside the United States? ☐ Yes ☐ No
   If Yes, explain:
10. In the next 2 years, do you have plans to travel outside the United States? ☐ Yes ☐ No
    If Yes, explain:
11. Have you piloted any type of aircraft in the past 2 years or intend to in the next 2 years? ☐ Yes ☐ No
    If Yes, explain:
12. Have you participated in any of the following sports in the past 5 years or intend to in the next 2 years? **(check all that apply)**
    - ☐ Automobile Racing
    - ☐ Backcountry Skiing/ Snowboarding/Snowmobiling
    - ☐ Base Jumping
    - ☐ Bicycle Racing
    - ☐ Boxing
    - ☐ Bungee Jumping
    - ☐ Drag Racing
    - ☐ Hang gliding or Paragliding
    - ☐ Helicopter Skiing/Snowboarding
    - ☐ Hot Air Ballooning
    - ☐ Martial Arts
    - ☐ Motorcycle Racing
    - ☐ Mountain, Rock or Ice Climbing
    - ☐ Mountain Biking
    - ☐ Parasailing
    - ☐ Power Boat Racing
    - ☐ Ski Mountaineering
    - ☐ Skin or Scuba Diving
    - ☐ Skydiving
    - ☐ Snowmobile Racing
    - ☐ I have not participated in any of these sports in the past 5 years nor intend to in the next 2 years.

Name 2

7. In the past 2 years have you lived outside, the United States? ☐ Yes ☐ No
   If Yes, explain:
8. In the next 2 years, do you have plans to live outside the United States? ☐ Yes ☐ No
   If Yes, explain:
9. In the past 2 years, have you traveled outside the United States? ☐ Yes ☐ No
   If Yes, explain:
10. In the next 2 years, do you have plans to travel outside the United States? ☐ Yes ☐ No
    If Yes, explain:
11. Have you piloted any type of aircraft in the past 2 years or intend to in the next 2 years? ☐ Yes ☐ No
    If Yes, explain:
12. Have you participated in any of the following sports in the past 5 years or intend to in the next 2 years? **(check all that apply)**
    - ☐ Automobile Racing
    - ☐ Backcountry Skiing/ Snowboarding/Snowmobiling
    - ☐ Base Jumping
    - ☐ Bicycle Racing
    - ☐ Boxing
    - ☐ Bungee Jumping
    - ☐ Drag Racing
    - ☐ Hang gliding or Paragliding
    - ☐ Helicopter Skiing/Snowboarding
    - ☐ Hot Air Ballooning
    - ☐ Martial Arts
    - ☐ Motorcycle Racing
    - ☐ Mountain, Rock or Ice Climbing
    - ☐ Mountain Biking
    - ☐ Parasailing
    - ☐ Power Boat Racing
    - ☐ Ski Mountaineering
    - ☐ Skin or Scuba Diving
    - ☐ Skydiving
    - ☐ Snowmobile Racing
    - ☐ I have not participated in any of these sports in the past 5 years nor intend to in the next 2 years.

PROPOSED INSURED(S)

Name 1 (First, Middle, Last, Suffix)

Birth Date (mm/dd/yyyy)

Name 2 (First, Middle, Last, Suffix) **– For Survivorship Products only**

Birth Date (mm/dd/yyyy)

PERSONAL INFORMATION (Continued)

Name 1

13. IN THE PAST 5 YEARS HAVE YOU:

a) been convicted of more than one moving violation? ☐ Yes ☐ No

If Yes, explain:

b) been in a motor vehicle accident in which you were found to be at fault or no contest? ☐ Yes ☐ No

If Yes, explain:

c) been convicted of driving while under the influence of alcohol or drugs? ☐ Yes ☐ No

If Yes, explain:

d) had your driver's license suspended or revoked? ☐ Yes ☐ No

If Yes, explain:

Name 2

13. IN THE PAST 5 YEARS HAVE YOU:

a) been convicted of more than one moving violation? ☐ Yes ☐ No

If Yes, explain:

b) been in a motor vehicle accident in which you were found to be at fault or no contest? ☐ Yes ☐ No

If Yes, explain:

c) been convicted of driving while under the influence of alcohol or drugs? ☐ Yes ☐ No

If Yes, explain:

d) had your driver's license suspended or revoked? ☐ Yes ☐ No

If Yes, explain:

PRIMARY PHYSICIAN/MEDICAL FACILITY

Name 1

What is the name of your Primary Physician or Medical Facility you have seen in the past 5 years?

Primary Physician or Medical Facility Address

Primary Physician or Medical Facility Telephone Number

☐ I don't have a Primary Physician or Medical Facility

Name 2

What is the name of your Primary Physician or Medical Facility you have seen in the past 5 years?

Primary Physician or Medical Facility Address

Primary Physician Or Medical Facility Telephone Number

☐ I don't have a Primary Physician or Medical Facility

PROPOSED INSURED(S)

Name 1 (First, Middle, Last, Suffix)

Birth Date (mm/dd/yyyy)

Name 2 (First, Middle, Last, Suffix) **– For Survivorship Products only**

Birth Date (mm/dd/yyyy)

MEDICAL CONDITIONS

This section is to be completed by the Proposed Insured(s) as it pertains to their own personal history. Answer each question and provide complete details to any Yes answers below in the Medical Condition Details.

IN THE PAST 10 YEARS, HAVE YOU BEEN DIAGNOSED, TREATED, OR CONSULTED WITH A MEMBER OF THE MEDICAL PROFESSION FOR ANY OF THE FOLLOWING MEDICAL CONDITIONS? (check all that apply)

1. Brain/Cerebrovascular/Nervous System

Name 1

- ☐ Alzheimer's
- ☐ Cognitive Impairment
- ☐ Dementia
- ☐ Epilepsy
- ☐ Headaches/Migraines
- ☐ Memory Loss
- ☐ Multiple Sclerosis
- ☐ Narcolepsy
- ☐ Neuropathy
- ☐ Paralysis
- ☐ Parkinson's Disease
- ☐ Restless Leg Syndrome
- ☐ Seizure
- ☐ Tremor
- ☐ Vertigo
- ☐ Other Neurological Condition not listed
- ☐ I have not been diagnosed, treated, or consulted with a member of the medical profession for any Brain, Cerebrovascular, or Nervous System Condition.

Name 2

- ☐ Alzheimer's
- ☐ Cognitive Impairment
- ☐ Dementia
- ☐ Epilepsy
- ☐ Headaches/Migraines
- ☐ Memory Loss
- ☐ Multiple Sclerosis
- ☐ Narcolepsy
- ☐ Neuropathy
- ☐ Paralysis
- ☐ Parkinson's Disease
- ☐ Restless Leg Syndrome
- ☐ Seizure
- ☐ Tremor
- ☐ Vertigo
- ☐ Other Neurological Condition not listed
- ☐ I have not been diagnosed, treated, or consulted with a member of the medical profession for any Brain, Cerebrovascular, or Nervous System Condition.

2. Heart Disorder/Heart Disease/Peripheral Vascular Disease

Name 1

- ☐ Aneurysm
- ☐ Atrial Fibrillation
- ☐ Chest Pain
- ☐ Coronary Artery Disease
- ☐ Deep Venous Thrombosis (DVT)
- ☐ Heart Attack
- ☐ Heart Murmur
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Irregular Heartbeat
- ☐ Mitral Valve Prolapse
- ☐ Palpitations
- ☐ Peripheral Vascular Disease
- ☐ Stroke
- ☐ Transient Ischemic Attack (TIA)
- ☐ Use of a Defibrillator
- ☐ Use of a Pacemaker
- ☐ Valve Disorder
- ☐ Other Heart, or Blood Vessel Condition not listed
- ☐ I have not been diagnosed, treated, or consulted with a member of the medical profession for any Heart Disorder, Heart Disease, or Peripheral Vascular Disease or Disorder.

Name 2

- ☐ Aneurysm
- ☐ Atrial Fibrillation
- ☐ Chest Pain
- ☐ Coronary Artery Disease
- ☐ Deep Venous Thrombosis (DVT)
- ☐ Heart Attack
- ☐ Heart Murmur
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Irregular Heartbeat
- ☐ Mitral Valve Prolapse
- ☐ Palpitations
- ☐ Peripheral Vascular Disease
- ☐ Stroke
- ☐ Transient Ischemic Attack (TIA)
- ☐ Use of a Defibrillator
- ☐ Use of a Pacemaker
- ☐ Valve Disorder
- ☐ Other Heart, or Blood Vessel Condition not listed
- ☐ I have not been diagnosed, treated, or consulted with a member of the medical profession for any Heart Disorder, Heart Disease, or Peripheral Vascular Disease or Disorder.

3. Cancer/Growths

Name 1

- ☐ Basal Cell Carcinoma
- ☐ Cancer
- ☐ Cyst
- ☐ Growth
- ☐ Hodgkin's Disease
- ☐ Leukemia
- ☐ Lymphoma
- ☐ Melanoma
- ☐ Neoplasm
- ☐ Nodule
- ☐ Polyp
- ☐ Squamous Cell Carcinoma
- ☐ Tumor
- ☐ Other Cancer, or Growth not listed
- ☐ I have not been diagnosed, treated, or consulted with a member of the medical profession for any Cancer, or Growth.

Name 2

- ☐ Basal Cell Carcinoma
- ☐ Cancer
- ☐ Cyst
- ☐ Growth
- ☐ Hodgkin's Disease
- ☐ Leukemia
- ☐ Lymphoma
- ☐ Melanoma
- ☐ Neoplasm
- ☐ Nodule
- ☐ Polyp
- ☐ Squamous Cell Carcinoma
- ☐ Tumor
- ☐ Other Cancer, or Growth not listed
- ☐ I have not been diagnosed, treated, or consulted with a member of the medical profession for any Cancer, or Growth.

PROPOSED INSURED(S)

Name 1 (First, Middle, Last, Suffix)	**Name 2** (First, Middle, Last, Suffix) **– For Survivorship Products only**
Birth Date (mm/dd/yyyy)	**Birth Date** (mm/dd/yyyy)

MEDICAL CONDITIONS (Continued)

IN THE PAST 10 YEARS, HAVE YOU BEEN DIAGNOSED, TREATED, OR CONSULTED WITH A MEMBER OF THE MEDICAL PROFESSION FOR ANY OF THE FOLLOWING MEDICAL CONDITIONS? (check all that apply)

4. Respiratory

Name 1	**Name 2**
☐ Asthma	☐ Asthma
☐ Bronchitis	☐ Bronchitis
☐ Chronic Obstructive Pulmonary Disease (COPD)	☐ Chronic Obstructive Pulmonary Disease (COPD)
☐ Emphysema	☐ Emphysema
☐ Other Lung, or Respiratory Condition not listed	☐ Other Lung, or Respiratory Condition not listed
☐ I have not been diagnosed, treated, or consulted with a member of the medical profession for any Respiratory Condition.	☐ I have not been diagnosed, treated, or consulted with a member of the medical profession for any Respiratory Condition.
☐ Pneumonia	☐ Pneumonia
☐ Sarcoidosis	☐ Sarcoidosis
☐ Sleep Apnea	☐ Sleep Apnea
☐ Tuberculosis	☐ Tuberculosis

5. Mental Health/Psychological

Name 1	**Name 2**
☐ ADD (Attention Deficit Disorder)	☐ ADD (Attention Deficit Disorder)
☐ ADHD (Attention Deficit Hyperactive Disorder)	☐ ADHD (Attention Deficit Hyperactive Disorder)
☐ Adjustment Disorder	☐ Adjustment Disorder
☐ Anxiety	☐ Anxiety
☐ Bipolar Disorder	☐ Bipolar Disorder
☐ Depression	☐ Depression
☐ Other Mental Health, or Psychological Condition not listed	☐ Other Mental Health, or Psychological Condition not listed
☐ I have not been diagnosed, treated, or consulted with a member of the medical profession for any Mental Health, or Psychological Condition.	☐ I have not been diagnosed, treated, or consulted with a member of the medical profession for any Mental Health, or Psychological Condition.
☐ Eating Disorder	☐ Eating Disorder
☐ OCD (Obsessive Compulsive Disorder)	☐ OCD (Obsessive Compulsive Disorder)
☐ Post-Traumatic Stress Disorder (PTSD)	☐ Post-Traumatic Stress Disorder (PTSD)
☐ Stress	☐ Stress

6. Gastrointestinal

Name 1	**Name 2**
☐ Barrett's Esophagus	☐ Barrett's Esophagus
☐ Cirrhosis	☐ Cirrhosis
☐ Crohn's Disease	☐ Crohn's Disease
☐ GERD/Acid Reflux	☐ GERD/Acid Reflux
☐ Hepatitis	☐ Hepatitis
☐ Other Liver, Gallbladder, Pancreas, or Digestive Tract Condition not listed	☐ Other Liver, Gallbladder, Pancreas, or Digestive Tract Condition not listed
☐ I have not been diagnosed, treated, or consulted with a member of the medical profession for any Gastrointestinal Condition.	☐ I have not been diagnosed, treated, or consulted with a member of the medical profession for any Gastrointestinal Condition.
☐ Irritable Bowel Syndrome	☐ Irritable Bowel Syndrome
☐ Pancreatitis	☐ Pancreatitis
☐ Ulcer	☐ Ulcer
☐ Ulcerative Colitis	☐ Ulcerative Colitis

7. Endocrine/Glandular

Name 1	**Name 2**
☐ Adrenal Disease or Disorder	☐ Adrenal Disease or Disorder
☐ Borderline Diabetes	☐ Borderline Diabetes
☐ Diabetes	☐ Diabetes
☐ Elevated Blood Glucose	☐ Elevated Blood Glucose
☐ Other Endocrine, or Glandular Condition not listed	☐ Other Endocrine, or Glandular Condition not listed
☐ I have not been diagnosed, treated, or consulted with a member of the medical profession for any Endocrine or Glandular Condition.	☐ I have not been diagnosed, treated, or consulted with a member of the medical profession for any Endocrine or Glandular Condition.
☐ Gestational Diabetes	☐ Gestational Diabetes
☐ Pituitary Disease or Disorder	☐ Pituitary Disease or Disorder
☐ Thyroid Disease or Disorder	☐ Thyroid Disease or Disorder

PROPOSED INSURED(S)

Name 1 (First, Middle, Last, Suffix)	**Name 2** (First, Middle, Last, Suffix) **– For Survivorship Products only**
Birth Date (mm/dd/yyyy)	**Birth Date** (mm/dd/yyyy)

▶ MEDICAL CONDITIONS (Continued)

IN THE PAST 10 YEARS, HAVE YOU BEEN DIAGNOSED, TREATED, OR CONSULTED WITH A MEMBER OF THE MEDICAL PROFESSION FOR ANY OF THE FOLLOWING MEDICAL CONDITIONS? (check all that apply)

8. Genitourinary

Name 1	**Name 2**
☐ Blood/Protein in the Urine	☐ Blood/Protein in the Urine
☐ Chronic Kidney Disease	☐ Chronic Kidney Disease
☐ Disease or Disorder of the Breast	☐ Disease or Disorder of the Breast
☐ Disease or Disorder of the Prostate	☐ Disease or Disorder of the Prostate
☐ Endometriosis	☐ Endometriosis
☐ Infertility	☐ Infertility
☐ Kidney Stones	☐ Kidney Stones
☐ Low Testosterone	☐ Low Testosterone
☐ Nephritis	☐ Nephritis
☐ Sexually Transmitted Disease/ Infection	☐ Sexually Transmitted Disease/ Infection
☐ Other Urinary, or Reproductive Condition not listed	☐ Other Urinary, or Reproductive Condition not listed
☐ I have not been diagnosed, treated, or consulted with a member of the medical profession for any Genitourinary Condition.	☐ I have not been diagnosed, treated, or consulted with a member of the medical profession for any Genitourinary Condition.

9. Eyes/Ears/Nose/Skin/Throat

Name 1	**Name 2**
☐ Dermatitis	☐ Dermatitis
☐ Glaucoma	☐ Glaucoma
☐ Hearing Loss	☐ Hearing Loss
☐ Keratoconus	☐ Keratoconus
☐ Lyme's Disease	☐ Lyme's Disease
☐ Macular Degeneration	☐ Macular Degeneration
☐ Meniere's Disease	☐ Meniere's Disease
☐ Psoriasis	☐ Psoriasis
☐ Tinnitus	☐ Tinnitus
☐ Other Ear, Eye, Nose, Skin, or Throat Condition not listed	☐ Other Ear, Eye, Nose, Skin, or Throat Condition not listed
☐ I have not been diagnosed, treated, or consulted with a member of the medical profession for any Eye, Ear, Nose, Skin, or Throat Condition.	☐ I have not been diagnosed, treated, or consulted with a member of the medical profession for any Eye, Ear, Nose, Skin, or Throat Condition.

10. Hematology/Immunology

Name 1	**Name 2**
☐ Allergies	☐ Allergies
☐ Anemia	☐ Anemia
☐ Bleeding Disorder	☐ Bleeding Disorder
☐ Clotting/Coagulation Disorder	☐ Clotting/Coagulation Disorder
☐ Systemic Lupus	☐ Systemic Lupus
☐ Other Blood, Bone Marrow, or Immune Condition not listed (excluding HIV or AIDS)	☐ Other Blood, Bone Marrow, or Immune Condition not listed (excluding HIV or AIDS)
☐ I have not been diagnosed, treated, or consulted with a member of the medical profession for any Hematology, or Immunology Condition.	☐ I have not been diagnosed, treated, or consulted with a member of the medical profession for any Hematology, or Immunology Condition.

11. Musculoskeletal

Name 1	**Name 2**
☐ Amputation	☐ Amputation
☐ Arthritis	☐ Arthritis
☐ Back Pain	☐ Back Pain
☐ Carpal Tunnel Syndrome	☐ Carpal Tunnel Syndrome
☐ Chronic Pain/Fatigue	☐ Chronic Pain/Fatigue
☐ Degenerative Disc Disease	☐ Degenerative Disc Disease
☐ Fibromyalgia	☐ Fibromyalgia
☐ Herniated Disc	☐ Herniated Disc
☐ Neck Pain	☐ Neck Pain
☐ Osteopenia/Osteoporosis	☐ Osteopenia/Osteoporosis
☐ Spine Pain	☐ Spine Pain
☐ Spinal Stenosis	☐ Spinal Stenosis
☐ Sciatica	☐ Sciatica
☐ Other Bone, Joint or Muscle Condition not listed	☐ Other Bone, Joint or Muscle Condition not listed
☐ Other Back, Spine, Neck, or Extremities Condition not listed	☐ Other Back, Spine, Neck, or Extremities Condition not listed
☐ I have not been diagnosed, treated, or consulted with a member of the medical profession for any Musculoskeletal Condition.	☐ I have not been diagnosed, treated, or consulted with a member of the medical profession for any Musculoskeletal Condition.

PROPOSED INSURED(S)

Name 1 (First, Middle, Last, Suffix)

Birth Date (mm/dd/yyyy)

Name 2 (First, Middle, Last, Suffix) **– For Survivorship Products only**

Birth Date (mm/dd/yyyy)

▶ MEDICAL CONDITION DETAILS (Enter details for every checkbox marked)

Name 1

Question Number	Condition Name/ Diagnosis	Date of Onset (Month/Year)	Treatment/ Medication	Name, Address, Phone Number of Physician or Medical Facility	Date Last Visited Physician or Medical Facility

Name 2

Question Number	Condition Name/ Diagnosis	Date of Onset (Month/Year)	Treatment/ Medication	Name, Address, Phone Number of Physician or Medical Facility	Date Last Visited Physician or Medical Facility

If more space is required, attach an additional page that has been signed by the Owner(s) and Proposed Insured(s).

PROPOSED INSURED(S)

Name 1 (First, Middle, Last, Suffix)

Birth Date (mm/dd/yyyy)

Name 2 (First, Middle, Last, Suffix) **– For Survivorship Products only**

Birth Date (mm/dd/yyyy)

MEDICAL / PHYSICAL HISTORY

Name 1

1. Are you currently pregnant?
   ☐ N/A ☐ Yes ☐ No
   If Yes, what is your anticipated due date?
   If Yes, what was your pre-pregnancy weight?
   If Yes, have you been treated, examined, or advised by a member of the medical profession for any complications with this current pregnancy?
   ☐ Yes ☐ No
   If Yes, explain:
2. In the past 10 years have you been diagnosed or treated with any pregnancy complications (including a Cesarean Section) by a member of the medical profession, excluding any current pregnancy complications?
   ☐ N/A ☐ Yes ☐ No
   If Yes, explain:
3. In the past 10 years have you tested positive for HIV (Human Immunodeficiency Virus) or been treated for or diagnosed by a member of the medical profession as having AIDS (Acquired Immunodeficiency Syndrome)?
   ☐ Yes ☐ No
   If Yes, explain:
4. What is your current height? ft. in.
5. What is your current weight? lbs.
6. In the past year have you lost more than 10 pounds?
   ☐ Yes ☐ No
   If Yes, provide amount of weight loss and details:
7. Have either of your biological parents lived to at least age 60?
   ☐ Yes ☐ No ☐ Unknown ☐ Alive and under 60
8. Have any of your biological parents or siblings been diagnosed or treated by a member of the medical profession for Heart Disease, Heart Attack, Diabetes, Stroke, or Cancer?
   ☐ Yes ☐ No ☐ Unknown
   If Yes, provide relationship, type of disease, age diagnosed, current age or age at death:

Name 2

1. Are you currently pregnant?
   ☐ N/A ☐ Yes ☐ No
   If Yes, what is your anticipated due date?
   If Yes, what was your pre-pregnancy weight?
   If Yes, have you been treated, examined, or advised by a member of the medical profession for any complications with this current pregnancy?
   ☐ Yes ☐ No
   If Yes, explain:
2. In the past 10 years have you been diagnosed or treated with any pregnancy complications (including a Cesarean Section) by a member of the medical profession, excluding any current pregnancy complications?
   ☐ N/A ☐ Yes ☐ No
   If Yes, explain:
3. In the past 10 years have you tested positive for HIV (Human Immunodeficiency Virus) or been treated for or diagnosed by a member of the medical profession as having AIDS (Acquired Immunodeficiency Syndrome)?
   ☐ Yes ☐ No
   If Yes, explain:
4. What is your current height? ft. in.
5. What is your current weight? lbs.
6. In the past year have you lost more than 10 pounds?
   ☐ Yes ☐ No
   If Yes, provide amount of weight loss and details:
7. Have either of your biological parents lived to at least age 60?
   ☐ Yes ☐ No ☐ Unknown ☐ Alive and under 60
8. Have any of your biological parents or siblings been diagnosed or treated by a member of the medical profession for Heart Disease, Heart Attack, Diabetes, Stroke, or Cancer?
   ☐ Yes ☐ No ☐ Unknown
   If Yes, provide relationship, type of disease, age diagnosed, current age or age at death:

PROPOSED INSURED(S)

Name 1 (First, Middle, Last, Suffix)

Birth Date (mm/dd/yyyy)

Name 2 (First, Middle, Last, Suffix) **– For Survivorship Products only**

Birth Date (mm/dd/yyyy)

MEDICAL / PHYSICAL HISTORY (Continued)

9. a) In the past 5 years, when was your last routine physical or checkup?

- ☐ Within the past year
- ☐ Within the past 1-2 years
- ☐ Within the past 3-5 years
- ☐ More than 5 years ago
- ☐ I've never had a routine physical or checkup

b) Was this routine physical or check-up performed with your Primary Physician, or Medical Facility? ☐ N/A ☐ Yes ☐ No

If No, indicate name, address, phone number of the Physician or Medical Facility:

c) If your last routine physical or checkup was within the past 5 years, which of these tests were performed? **(check all that apply)**

- ☐ Blood Test
- ☐ Breast Exam
- ☐ Colonoscopy
- ☐ CT Scan
- ☐ Echocardiogram
- ☐ EKG/ECG
- ☐ Mammogram
- ☐ MRI
- ☐ Pap Smear
- ☐ Prostate Exam
- ☐ Pulmonary Test
- ☐ Skin Check
- ☐ Stress Test
- ☐ Ultrasound
- ☐ Urinalysis
- ☐ X-Ray
- ☐ Other
- ☐ None
- ☐ N/A

d) If your last routine physical or checkup was within the past 5 years, what were the results of the check-up including any tests? ☐ N/A

Please explain:

e) If your last routine physical or checkup was within the past 5 years, did your physician advise any additional treatment or tests, which have not been completed? ☐ N/A ☐ Yes ☐ No

If Yes, explain:

10. IN THE PAST 5 YEARS, HAVE YOU:

a) been treated, examined, or advised by a member of the medical profession for any of the following not provided in response to a previous question?

- ☐ Hospitalization
- ☐ Illness
- ☐ Injury
- ☐ Medical Condition
- ☐ None

If any box is checked, explain in detail:

9. a) In the past 5 years, when was your last routine physical or checkup?

- ☐ Within the past year
- ☐ Within the past 1-2 years
- ☐ Within the past 3-5 years
- ☐ More than 5 years ago
- ☐ I've never had a routine physical or checkup

b) Was this routine physical or check-up performed with your Primary Physician, or Medical Facility? ☐ N/A ☐ Yes ☐ No

If No, indicate name, address, phone number of the Physician or Medical Facility:

c) If your last routine physical or checkup was within the past 5 years, which of these tests were performed? **(check all that apply)**

- ☐ Blood Test
- ☐ Breast Exam
- ☐ Colonoscopy
- ☐ CT Scan
- ☐ Echocardiogram
- ☐ EKG/ECG
- ☐ Mammogram
- ☐ MRI
- ☐ Pap Smear
- ☐ Prostate Exam
- ☐ Pulmonary Test
- ☐ Skin Check
- ☐ Stress Test
- ☐ Ultrasound
- ☐ Urinalysis
- ☐ X-Ray
- ☐ Other
- ☐ None
- ☐ N/A

d) If your last routine physical or checkup was within the past 5 years, what were the results of the check-up including any tests? ☐ N/A

Please explain:

e) If your last routine physical or checkup was within the past 5 years, did your physician advise any additional treatment or tests, which have not been completed? ☐ N/A ☐ Yes ☐ No

If Yes, explain:

10. IN THE PAST 5 YEARS, HAVE YOU:

a) been treated, examined, or advised by a member of the medical profession for any of the following not provided in response to a previous question?

- ☐ Hospitalization
- ☐ Illness
- ☐ Injury
- ☐ Medical Condition
- ☐ None

If any box is checked, explain in detail:

PROPOSED INSURED(S)

Name 1 (First, Middle, Last, Suffix)

Birth Date (mm/dd/yyyy)

Name 2 (First, Middle, Last, Suffix) **– For Survivorship Products only**

Birth Date (mm/dd/yyyy)

MEDICAL / PHYSICAL HISTORY (Continued)

Name 1

10. IN THE PAST 5 YEARS, HAVE YOU:

b) consulted any of the following not provided in response to a previous question?

- ☐ Doctor
- ☐ Chiropractor
- ☐ Counselor/Therapist
- ☐ Physical Therapist
- ☐ Psychiatrist/Psychologist
- ☐ Specialist
- ☐ Other healthcare provider or medical facility
- ☐ None

If any box is checked, explain reason for visit, date of last visit, and name, address of Physician or Medical Facility:

c) taken or have been prescribed any of the following for any reason not previously provided?

- ☐ Medication
- ☐ Supplement
- ☐ Treatment
- ☐ None

If any box is checked, explain in detail:

d) had any of the following test(s) performed that has not been provided in a response to a previous question? **(check all that apply)**

- ☐ Blood Test
- ☐ Breast Exam
- ☐ Colonoscopy
- ☐ CT Scan
- ☐ Echocardiogram
- ☐ EKG/ECG
- ☐ Mammogram
- ☐ MRI
- ☐ Pap Smear
- ☐ Prostate Exam
- ☐ Pulmonary Test
- ☐ Skin Check
- ☐ Stress Test
- ☐ Ultrasound
- ☐ Urinalysis
- ☐ X-Ray
- ☐ Other
- ☐ None

e) What were the results of the check-up including any tests? ☐ N/A

Please explain:

Name 2

10. IN THE PAST 5 YEARS, HAVE YOU:

b) consulted any of the following not provided in response to a previous question?

- ☐ Doctor
- ☐ Chiropractor
- ☐ Counselor/Therapist
- ☐ Physical Therapist
- ☐ Psychiatrist/Psychologist
- ☐ Specialist
- ☐ Other healthcare provider or medical facility
- ☐ None

If any box is checked, explain reason for visit, date of last visit, and name, address of Physician or Medical Facility:

c) taken or have been prescribed any of the following for any reason not previously provided?

- ☐ Medication
- ☐ Supplement
- ☐ Treatment
- ☐ None

If any box is checked, explain in detail:

d) had any of the following test(s) performed that has not been provided in a response to a previous question? **(check all that apply)**

- ☐ Blood Test
- ☐ Breast Exam
- ☐ Colonoscopy
- ☐ CT Scan
- ☐ Echocardiogram
- ☐ EKG/ECG
- ☐ Mammogram
- ☐ MRI
- ☐ Pap Smear
- ☐ Prostate Exam
- ☐ Pulmonary Test
- ☐ Skin Check
- ☐ Stress Test
- ☐ Ultrasound
- ☐ Urinalysis
- ☐ X-Ray
- ☐ Other
- ☐ None

e) What were the results of the check-up including any tests? ☐ N/A

Please explain:

▶ AGREEMENT / SIGNATURE(S)

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

The Proposed Insured(s) (or Parent/Guardian) agree that they have read the application and all statements and answers as they pertain to the Proposed Insured(s), and that these statements and answers are true and complete to the best of the Proposed Insured's knowledge and belief. In addition, I/we understand and agree that:

Application Responses: The statements in the application, including statements by the Proposed Insured(s) 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.

Proposed Insured

Signature of **Proposed Insured Name 1** (If age 15 or over)

X

Signature of **Proposed Insured Name 2** (If age 15 or over)

X

Signature of **Parent/Guardian** (If Proposed Insured is under age 18 and Parent/Guardian has not signed as Owner)

X

Signed At:

City	State	Date (mm/dd/yyyy)

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

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

Authorization for Release of Personal Health Information – All States

(Applicable to Individual Life and Disability Insurance Customers)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

I hereby authorize the Company, their employees, officers, and affiliates to disclose any and all medical information ("Information"), which has been collected by the Company in connection with my current request for life insurance or disability insurance to the Field Office and Financial Professional submitting that life insurance or disability insurance request. I understand that I am not required to sign this Authorization, and that signing, not signing or revoking this Authorization will not affect my eligibility for insurance issued by the Company.

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

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

I further understand that if we provide a copy of your medical information to the Field Office and Financial Professional the Company's privacy policy does not apply.

I understand that I have a right to revoke this Authorization at any time by sending a revocation in writing to the Company at the address above. I also understand that any such revocation will not be effective to the extent that action has been taken by the Company in reliance on this Authorization prior to the Company's receipt of my revocation.

Unless revoked as outlined above, this Authorization will be valid for 24 months from the date of my signature below unless otherwise provided by law.

A copy of this Authorization will be as valid as the original.

Proposed Insured Name (Please Print)	
Proposed Insured's Signature **X**	Date

Principal®

FACTS	WHAT DOES PRINCIPAL® DO WITH YOUR PERSONAL INFORMATION?
Why?	Financial companies choose how they share your personal information. Federal law gives consumers the right to limit some but not all sharing. Federal law also requires us to tell you how we collect, share, and protect your personal information. Please read this notice carefully to understand what we do.
What?	The types of personal information we collect and share depend on the product or service you have with us. This information can include: • Social Security number, credit history, credit scores, income, or payment history • Account transactions, account balances, and account investment experience • Medical information
How?	All financial companies need to share customers' personal information to run their everyday business. In the section below, we list the reasons financial companies can share their customers' personal information; the reasons Principal chooses to share; and whether you can limit this sharing.

REASONS WE CAN SHARE YOUR PERSONAL INFORMATION	DOES PRINCIPAL SHARE?	CAN YOU LIMIT THIS SHARING?
For our everyday business purposes—such as to process your transactions, maintain your account(s), respond to court orders and legal investigations, or report to credit bureaus	Yes	No
For our marketing purposes—to offer our products and services to you	Yes	No
For joint marketing with other financial companies	No	We don't share
For our affiliates' everyday business purposes—information about your transactions and experiences	Yes	No
For our affiliates' everyday business purposes—information about your creditworthiness	No	We don't share
For our affiliates to market to you	No	We don't share
For nonaffiliates to market to you (All entities other than Principal Securities, Inc.)	No	We don't share
For nonaffiliates to market to you (Applies only to Principal Securities, Inc. ("PSI"), and only if your financial professional changes their affiliation and leaves PSI.)	Yes	Yes

To limit our sharing	To limit Principal Securities, Inc.'s sharing with nonaffiliates, call 1.800.986.3343 or visit https://www.principal.com/optout-principalsecurities. **Please note:** If you are a *new* customer, we can begin sharing your information 45 days from the date we sent this notice. When you are *no longer* our customer, we continue to share your information as described in this notice. However, you can contact us at any time to limit our sharing.
Questions?	Call 1.800.986.3343 or visit https://www.principal.com/privacy-policies for additional information.

Who we are	
Who is providing this notice?	The following Principal Financial Group® companies: Principal Life Insurance Company; Principal National Life Insurance Company; Principal Funds, Inc.; Principal Global Investors, LLC; Principal Real Estate Investors, LLC; Principal Securities, Inc.; Principal Advised Services, LLC; Principal Trust Company; Principal Funds Distributor, Inc.; Spectrum Asset Management, Inc.; Employers Dental Services, Inc.; and Principal Dental Services, Inc. Additional entities to which this notice applies are listed in the "Other important information" section below.

What we do	
How does Principal protect my personal information?	To protect your personal information from unauthorized access and use, we use security measures that comply with federal and state laws. These measures include computer safeguards and secured files and buildings.
How does Principal collect my personal information?	We collect your personal information, for example, when you • Open an account, apply for insurance, or seek advice about your investments • Direct us to buy securities or make deposits or withdrawals from your account • File an insurance claim We also collect your personal information from others, such as affiliates, credit bureaus or other companies.
Why can't I limit all sharing?	Federal and state laws give you the right to limit only • Sharing for affiliates' everyday business purposes—information about your creditworthiness • Affiliates from using your information to market to you • Sharing for nonaffiliates to market to you State laws and individual companies may give you additional rights to limit sharing. See below for more on your rights under state law.
What happens when I limit sharing for an account, I hold jointly with someone else?	Your choices will apply to everyone on your account.
Definitions	
Affiliates	Companies related by common ownership or control. They can be financial and nonfinancial companies. • Our affiliates include companies of Principal Financial Group and other companies of Principal name.
Nonaffiliates	Companies not related by common ownership or control. They can be financial and nonfinancial companies. • Your financial professional and their new financial institution if he/she changes his/her affiliation and leaves Principal Securities.
Joint marketing	A formal agreement between nonaffiliated financial companies that together market financial products or services to you. • Principal does not jointly market.

Other important information

In addition to the companies listed above, this notice applies to: All funds or other vehicles advised, organized, or managed by Principal Global Investors, LLC, Principal Real Estate Investors, LLC, or their affiliates; Principal Diversified Select Real Asset Fund; Principal Life Insurance Company Variable Life Separate Account; Principal National Life Insurance Company Variable Life Separate Account; and Principal Life Insurance Company Separate Account B.

Nevada Residents: You may request to be placed on our internal Do Not Call list. Send an email with your phone number to connect@principal.com. You may request a copy of our telemarketing practices. For more on this Nevada law, contact Bureau of Consumer Protection, Office of the Nevada Attorney General, 555 E. Washington St., Suite 3900, Las Vegas, NV 89101; phone number: 1.702.486.3132; email: BCPINFO@ag.state.nv.us.

For Vermont Customers: We will not disclose information about your creditworthiness to our affiliates and will not disclose your personal information, financial information, credit report, or health information to nonaffiliated third parties to market to you, other than as permitted by Vermont law, unless you authorize us to make those disclosures.

California: Under California law, we will not share information we collect about you with companies outside of Principal, unless the law allows. For example, we may share information with your consent, to service your accounts, or to provide rewards or benefits you are entitled to. We will limit sharing among our companies to the extent required by California law.

For insurance customers in AZ, CT, GA, IL, ME, MA, MT, NV, NJ, NM, NC, ND, OH, OR, and VA only: The term "information" means information we collect during an insurance transaction. We will not use your medical information for marketing purposes without your consent. We may share your Information with others, including insurance-support organizations, insurance regulatory authorities, law enforcement, and consumer reporting agencies, without your prior authorization as permitted or required by law. Information obtained from a report prepared by an insurance-support organization may be retained by the insurance-support organization and disclosed to other persons.

For MA Insurance Customers only. You may ask, in writing, for the specific reasons for an adverse underwriting decision. An adverse underwriting decision is where we decline your application for insurance, offer to insure you at a higher than standard rate or terminate your coverage.

For insurance customers, to request access to or deletion of your personal information, send a written letter to Privacy Officer, P.O. Box 14582, Des Moines, IA 50306-3582. Include your name, address, and your policy, contract, or account number, and describe the information you wish to access or delete. You may correct inaccurate personal information by sending a written letter identifying the information to be corrected. We can't change information other companies, like credit agencies, provide to us. You'll need to ask them to change it.

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

Disability Insurance
Notice of Insurance Information Practices

We appreciate you applying for insurance with our company.

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

Overview

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

Sources and Types of Information

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

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

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

Our Use of Information

We follow strict standards to safeguard your personal information. It will be seen only by employees and agents of Principal Life Insurance Company who underwrite and administer your coverage. With your authorization, we may also provide data to: (1) MIB, Inc.; (2) other insurance companies; or (3) our reinsurers, if needed to secure reinsurance. In some circumstances your information may be disclosed without a need for authorization and in accordance with applicable law to: (1) federal and state agencies and others, if required by law; (2) an insurance regulatory authority; or (3) others conducting actuarial or research studies on our behalf anonymously, as permitted by law.

Access To Your Data

Upon your written request, we will provide you with the nature and scope of your personal data in our records. You must give us proper identification. You may be charged a fee for any copies of your data. You have the right to know what information we have on file about you. You have the right to know the specific information leading to an adverse underwriting decision and the source of that information. In the event of an adverse underwriting decision you have the right to request in writing, within 90 business days, the specific reasons for the decision. We reserve the right to disclose medical information only to a doctor, and we will request that you provide us with the name and address of your physician. Within 21 days from the date we receive your request, we will furnish you and/or your doctor the specific reasons for our decision and the specific items in your file that support the decision that you are entitled to receive. You have the right to correct or amend any data in your file. Any request for correction or amendment must be in writing. Within 30 days of receipt of your written request, we will notify you of our correction, amendment or deletion of the information in dispute, or our refusal to make such correction, amendment or deletion of the information after further investigation. In the event that we refuse to correct, amend or delete the information in dispute, you have the right to submit to us a written statement of the reasons for your disagreement with our assessment of the information in dispute and what you consider to be the correct information. We will make such a statement accessible to any and all parties reviewing the information in dispute.

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

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

— CONTINUED —

DISCLOSURE – Give to Proposed Insured

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.

Consumer Disclosure and Consent

PLEASE READ THIS DISCLOSURE AND CONSENT CAREFULLY. PRINT OR DOWNLOAD A COPY FOR YOUR RECORDS.

Consumer Disclosure and Consent Regarding Conducting Business Electronically, Including Receiving and Signing Records Electronically

Please read the following information. You are not required to conduct business electronically or to receive or sign Records (defined below) electronically. If you wish to continue receiving paper Records and do not wish to sign Records electronically, you do not need to consent to the terms of this Disclosure and Consent.

By proceeding forward and electronically indicating your acceptance of the terms of this Disclosure and Consent you are agreeing that you have reviewed the following information and voluntarily consent to the terms of this Disclosure and Consent and to conduct business electronically, including receiving and signing Records electronically.

Scope of Consent

By electronically indicating your acceptance of the terms of this Disclosure and Consent, you voluntarily consent to receive and sign electronically all documents relating to the application, issuance and administration of insurance policies, including but not limited to applications, notices, disclosures, authorizations, acknowledgements and delivery receipts (collectively "Records") provided over the course of your relationship with Principal Life Insurance Company or Principal National Life Insurance Company, hereinafter collectively referred to as "the Company". You may, at any time, withdraw your consent.

Withdrawal of Consent

In order to withdraw consent you must notify the Company using one of the methods in the Contact Information section below that you choose to withdraw your consent and wish to receive future Records in paper format and do not wish to sign Records electronically. Once the Company has received such notification, your request to withdraw consent will be effective as soon as reasonably possible. You may withdraw consent by following the procedures described in the Contact Information section below. There are no fees associated with the withdrawal of your consent.

Paper Copies

After you consent to receive Records electronically you may request paper copies of Records you have received electronically. If you wish to receive paper copies of electronically delivered Records please contact the Company using one of the methods described in the Contact Information section below. The Company will provide paper copies of Records at your request, free of charge, on an annual basis.

Contact Information

Please use one of the following methods to contact the Company to withdraw your consent to do business electronically, request a free paper copy of electronically delivered Records annually, or report a change in your email address:

- Email: Individual Life products: IndLifeService@exchange.principal.com
  Individual Disability products: DIService@principal.com
- Telephone: 1-800-247-9988
- Paper: Individual Life products: P.O. Box 10431, Des Moines, IA 50306-0431
  Individual Disability products: P.O. Box 14455, Des Moines, IA 50306-3455
- On the Company's website at: www.principal.com

Computer Hardware and Software Requirements

The computer hardware and software used to access this Web site and this Disclosure and Consent are all you will need to access the Records provided to you in electronic form. This includes your use of a standards-compliant web-browser which supports the HTTPS protocol, HTML, and acceptance of cookies in your security settings. Viewing and retention of PDF documents requires additional software (available free for Download) such as Adobe Reader or similar.

*** These minimum requirements are subject to change. Pre-release (e.g. beta) versions of operating systems and browsers are not supported.*

How to Submit Your Application

Unsigned applications are welcome.

Feel free to omit your SSN. Most applications need to be revised anyway.

Fax

(206) 899 1356

Upload

https://disabilityunderwriters.com/upload

DocuSign

If you are viewing this within DocuSign, just complete the session.

Email

rip@ripcurtis.com

Do not use ordinary email. Use a secure message portal or Outlook native encryption. If you don't know how, please ask.

Rip W. Curtis
Disability Underwriters
1420 5th Avenue, Suite 2200 Seattle, WA 98101
(206) 652 2266

State insurance license numbers

Alabama 693034
Alaska 0109096
Arkansas 670169
Arizona 1034318
California 0B73499
Colorado 351718
Connecticut 2625242
Delaware 3000471370
District of Columbia 3000085210
Florida W004391
Georgia 3009530
Hawaii 486346
Idaho 292989
Illinois 670169
Indiana 3411220
Iowa 670169
Kansas 670169
Kentucky 1026779
Louisiana 727692
Maine PRN325152
Maryland 3000002183
Massachusetts 1932470
Montana 3000276492
Michigan 0721730
Minnesota 40519161
Mississippi 10594113
Missouri 8345962
Nebraska 0670169
Nevada 3157202
New Hampshire 670169
New Jersey 1576772
New Mexico 670169
New York 1484281
North Carolina 0670169
North Dakota 670169
Ohio 769705
Oklahoma 3000471388
Oregon 670169
Pennsylvania 847459
Rhode Is. 3000471373
South Carolina 670169
South Dakota 40507150
Tennessee 2047645
Texas 1726888
Utah 483697
Vermont 3411471
Virginia 895401
Washington 118074
West Virginia 670169
Wisconsin 2635185
Wyoming 391239