



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**

1. What is your primary occupation?

2. Type of business or industry?

3. What is the name of your employer?

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)




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?

  %

  %

  %

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:

**Name 2**

1. What is your primary occupation?

2. Type of business or industry?

3. What is the name of your employer?

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)




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?

  %

  %

  %

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:

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**▶ 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)?

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**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:



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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cigars	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chewing tobacco or snuff	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nicotine gum or patch	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E-cigarette or vaping products	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cigars	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chewing tobacco or snuff	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nicotine gum or patch	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E-cigarette or vaping products	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If Other is selected, explain:

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**PERSONAL INFORMATION (Continued)**

**Name 1**

5. How many alcoholic beverages do you drink per week?
- |                                |  |
|--------------------------------|--|
| <input type="checkbox"/> None  | <input type="checkbox"/> 43 or more  |
| <input type="checkbox"/> 1-7   | <input type="checkbox"/> Temporarily not drinking (pregnancy, nursing, training) |
| <input type="checkbox"/> 8-14  |  |
| <input type="checkbox"/> 15-21 | <input type="checkbox"/> Special Occasions                                       |
| <input type="checkbox"/> 22-28 | <input type="checkbox"/> No longer drinking                                      |
| <input type="checkbox"/> 29-35 | <input type="checkbox"/> I've never drank  |
| <input type="checkbox"/> 36-42 |  |

**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)
- |   |   |
|---|---|
| <input type="checkbox"/> CBD Product(s)         | <input type="checkbox"/> Smoked Marijuana |
| <input type="checkbox"/> Edibles                | <input type="checkbox"/> Vaping           |
| <input type="checkbox"/> Other (please explain) |   |
- 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?
- |                                |  |
|--------------------------------|--|
| <input type="checkbox"/> None  | <input type="checkbox"/> 43 or more  |
| <input type="checkbox"/> 1-7   | <input type="checkbox"/> Temporarily not drinking (pregnancy, nursing, training) |
| <input type="checkbox"/> 8-14  |  |
| <input type="checkbox"/> 15-21 | <input type="checkbox"/> Special Occasions                                       |
| <input type="checkbox"/> 22-28 | <input type="checkbox"/> No longer drinking                                      |
| <input type="checkbox"/> 29-35 | <input type="checkbox"/> I've never drank  |
| <input type="checkbox"/> 36-42 |  |

**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)
- |   |   |
|---|---|
| <input type="checkbox"/> CBD Product(s)         | <input type="checkbox"/> Smoked Marijuana |
| <input type="checkbox"/> Edibles                | <input type="checkbox"/> Vaping           |
| <input type="checkbox"/> Other (please explain) |   |
- 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: \_\_\_\_\_

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**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)**

- |  |  |
|--|--|
| <input type="checkbox"/> Automobile Racing   | <input type="checkbox"/> Motorcycle Racing                 |
| <input type="checkbox"/> Backcountry Skiing/<br>Snowboarding/Snowmobiling  | <input type="checkbox"/> Mountain, Rock or<br>Ice Climbing |
| <input type="checkbox"/> Base Jumping  | <input type="checkbox"/> Mountain Biking                   |
| <input type="checkbox"/> Bicycle Racing  | <input type="checkbox"/> Parasailing                       |
| <input type="checkbox"/> Boxing  | <input type="checkbox"/> Power Boat Racing                 |
| <input type="checkbox"/> Bungee Jumping  | <input type="checkbox"/> Ski Mountaineering                |
| <input type="checkbox"/> Drag Racing   | <input type="checkbox"/> Skin or Scuba<br>Diving           |
| <input type="checkbox"/> Hang gliding or Paragliding   | <input type="checkbox"/> Skydiving                         |
| <input type="checkbox"/> Helicopter Skiing/Snowboarding  | <input type="checkbox"/> Snowmobile Racing                 |
| <input type="checkbox"/> Hot Air Ballooning  |  |
| <input type="checkbox"/> Martial Arts  |  |
| <input type="checkbox"/> 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)**

- |  |  |
|--|--|
| <input type="checkbox"/> Automobile Racing   | <input type="checkbox"/> Motorcycle Racing                 |
| <input type="checkbox"/> Backcountry Skiing/<br>Snowboarding/Snowmobiling  | <input type="checkbox"/> Mountain, Rock or<br>Ice Climbing |
| <input type="checkbox"/> Base Jumping  | <input type="checkbox"/> Mountain Biking                   |
| <input type="checkbox"/> Bicycle Racing  | <input type="checkbox"/> Parasailing                       |
| <input type="checkbox"/> Boxing  | <input type="checkbox"/> Power Boat Racing                 |
| <input type="checkbox"/> Bungee Jumping  | <input type="checkbox"/> Ski Mountaineering                |
| <input type="checkbox"/> Drag Racing   | <input type="checkbox"/> Skin or Scuba<br>Diving           |
| <input type="checkbox"/> Hang gliding or Paragliding   | <input type="checkbox"/> Skydiving                         |
| <input type="checkbox"/> Helicopter Skiing/Snowboarding  | <input type="checkbox"/> Snowmobile Racing                 |
| <input type="checkbox"/> Hot Air Ballooning  |  |
| <input type="checkbox"/> Martial Arts  |  |
| <input type="checkbox"/> I have not participated in any of these sports in the past 5 years nor intend to in the next 2 years. |  |

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**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

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**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

- |  |  |
|--|--|
| <input type="checkbox"/> Alzheimer's   | <input type="checkbox"/> Neuropathy            |
| <input type="checkbox"/> Cognitive Impairment  | <input type="checkbox"/> Paralysis             |
| <input type="checkbox"/> Dementia  | <input type="checkbox"/> Parkinson's Disease   |
| <input type="checkbox"/> Epilepsy  | <input type="checkbox"/> Restless Leg Syndrome |
| <input type="checkbox"/> Headaches/Migraines   | <input type="checkbox"/> Seizure               |
| <input type="checkbox"/> Memory Loss   | <input type="checkbox"/> Tremor                |
| <input type="checkbox"/> Multiple Sclerosis  | <input type="checkbox"/> Vertigo               |
| <input type="checkbox"/> Narcolepsy  |  |
| <input type="checkbox"/> Other Neurological Condition not listed   |  |
| <input type="checkbox"/> 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

- |  |  |
|--|--|
| <input type="checkbox"/> Alzheimer's   | <input type="checkbox"/> Neuropathy            |
| <input type="checkbox"/> Cognitive Impairment  | <input type="checkbox"/> Paralysis             |
| <input type="checkbox"/> Dementia  | <input type="checkbox"/> Parkinson's Disease   |
| <input type="checkbox"/> Epilepsy  | <input type="checkbox"/> Restless Leg Syndrome |
| <input type="checkbox"/> Headaches/Migraines   | <input type="checkbox"/> Seizure               |
| <input type="checkbox"/> Memory Loss   | <input type="checkbox"/> Tremor                |
| <input type="checkbox"/> Multiple Sclerosis  | <input type="checkbox"/> Vertigo               |
| <input type="checkbox"/> Narcolepsy  |  |
| <input type="checkbox"/> Other Neurological Condition not listed   |  |
| <input type="checkbox"/> 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

- |  |  |
|--|--|
| <input type="checkbox"/> Aneurysm  | <input type="checkbox"/> Irregular Heartbeat             |
| <input type="checkbox"/> Atrial Fibrillation   | <input type="checkbox"/> Mitral Valve Prolapse           |
| <input type="checkbox"/> Chest Pain  | <input type="checkbox"/> Palpitations                    |
| <input type="checkbox"/> Coronary Artery Disease   | <input type="checkbox"/> Peripheral Vascular Disease     |
| <input type="checkbox"/> Deep Venous Thrombosis (DVT)  | <input type="checkbox"/> Stroke                          |
| <input type="checkbox"/> Heart Attack  | <input type="checkbox"/> Transient Ischemic Attack (TIA) |
| <input type="checkbox"/> Heart Murmur  | <input type="checkbox"/> Use of a Defibrillator          |
| <input type="checkbox"/> High Blood Pressure   | <input type="checkbox"/> Use of a Pacemaker              |
| <input type="checkbox"/> High Cholesterol  | <input type="checkbox"/> Valve Disorder                  |
| <input type="checkbox"/> Other Heart, or Blood Vessel Condition not listed   |  |
| <input type="checkbox"/> 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

- |  |  |
|--|--|
| <input type="checkbox"/> Aneurysm  | <input type="checkbox"/> Irregular Heartbeat             |
| <input type="checkbox"/> Atrial Fibrillation   | <input type="checkbox"/> Mitral Valve Prolapse           |
| <input type="checkbox"/> Chest Pain  | <input type="checkbox"/> Palpitations                    |
| <input type="checkbox"/> Coronary Artery Disease   | <input type="checkbox"/> Peripheral Vascular Disease     |
| <input type="checkbox"/> Deep Venous Thrombosis (DVT)  | <input type="checkbox"/> Stroke                          |
| <input type="checkbox"/> Heart Attack  | <input type="checkbox"/> Transient Ischemic Attack (TIA) |
| <input type="checkbox"/> Heart Murmur  | <input type="checkbox"/> Use of a Defibrillator          |
| <input type="checkbox"/> High Blood Pressure   | <input type="checkbox"/> Use of a Pacemaker              |
| <input type="checkbox"/> High Cholesterol  | <input type="checkbox"/> Valve Disorder                  |
| <input type="checkbox"/> Other Heart, or Blood Vessel Condition not listed   |  |
| <input type="checkbox"/> 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

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

Name 2

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

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**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

- Asthma  Pneumonia  
 Bronchitis  Sarcoidosis  
 Chronic Obstructive Pulmonary Disease (COPD)  Sleep Apnea  Tuberculosis  
 Emphysema  
 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.

Name 2

- Asthma  Pneumonia  
 Bronchitis  Sarcoidosis  
 Chronic Obstructive Pulmonary Disease (COPD)  Sleep Apnea  Tuberculosis  
 Emphysema  
 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.

**5. Mental Health/Psychological**

Name 1

- ADD (Attention Deficit Disorder)  Eating Disorder  
 ADHD (Attention Deficit Hyperactive Disorder)  OCD (Obsessive Compulsive Disorder)  
 Adjustment Disorder  Post-Traumatic Stress Disorder (PTSD)  
 Anxiety  Stress  
 Bipolar Disorder  Stress  
 Depression  
 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.

Name 2

- ADD (Attention Deficit Disorder)  Eating Disorder  
 ADHD (Attention Deficit Hyperactive Disorder)  OCD (Obsessive Compulsive Disorder)  
 Adjustment Disorder  Post-Traumatic Stress Disorder (PTSD)  
 Anxiety  Stress  
 Bipolar Disorder  Stress  
 Depression  
 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.

**6. Gastrointestinal**

Name 1

- Barrett's Esophagus  Irritable Bowel Syndrome  
 Cirrhosis  Pancreatitis  
 Crohn's Disease  Ulcer  
 GERD/Acid Reflux  Ulcerative Colitis  
 Hepatitis  
 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.

Name 2

- Barrett's Esophagus  Irritable Bowel Syndrome  
 Cirrhosis  Pancreatitis  
 Crohn's Disease  Ulcer  
 GERD/Acid Reflux  Ulcerative Colitis  
 Hepatitis  
 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.

**7. Endocrine/Glandular**

Name 1

- Adrenal Disease or Disorder  Gestational Diabetes  
 Borderline Diabetes  Pituitary Disease or Disorder  
 Diabetes  Thyroid Disease or Disorder  
 Elevated Blood Glucose  
 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.

Name 2

- Adrenal Disease or Disorder  Gestational Diabetes  
 Borderline Diabetes  Pituitary Disease or Disorder  
 Diabetes  Thyroid Disease or Disorder  
 Elevated Blood Glucose  
 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.

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**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**

- Blood/Protein in the Urine       Infertility  
 Chronic Kidney Disease       Kidney Stones  
 Disease or Disorder of the Breast       Low Testosterone  
 Disease or Disorder of the Prostate       Nephritis  
 Endometriosis       Sexually Transmitted Disease/ Infection  
 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.

**Name 2**

- Blood/Protein in the Urine       Infertility  
 Chronic Kidney Disease       Kidney Stones  
 Disease or Disorder of the Breast       Low Testosterone  
 Disease or Disorder of the Prostate       Nephritis  
 Endometriosis       Sexually Transmitted Disease/ Infection  
 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.

**9. Eyes/Ears/Nose/Skin/Throat****Name 1**

- Dermatitis       Macular Degeneration  
 Glaucoma       Meniere's Disease  
 Hearing Loss       Psoriasis  
 Keratoconus       Tinnitus  
 Lyme's Disease  
 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.

**Name 2**

- Dermatitis       Macular Degeneration  
 Glaucoma       Meniere's Disease  
 Hearing Loss       Psoriasis  
 Keratoconus       Tinnitus  
 Lyme's Disease  
 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.

**10. Hematology/Immunology****Name 1**

- Allergies       Clotting/Coagulation Disorder  
 Anemia       Systemic Lupus  
 Bleeding Disorder  
 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.

**Name 2**

- Allergies       Clotting/Coagulation Disorder  
 Anemia       Systemic Lupus  
 Bleeding Disorder  
 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.

**11. Musculoskeletal****Name 1**

- Amputation       Neck Pain  
 Arthritis       Osteopenia/Osteoporosis  
 Back Pain       Spine Pain  
 Carpal Tunnel Syndrome       Spinal Stenosis  
 Chronic Pain/Fatigue       Sciatica  
 Degenerative Disc Disease       Other Bone, Joint or Muscle Condition not listed  
 Fibromyalgia  
 Herniated Disc  
 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.

**Name 2**

- Amputation       Neck Pain  
 Arthritis       Osteopenia/Osteoporosis  
 Back Pain       Spine Pain  
 Carpal Tunnel Syndrome       Spinal Stenosis  
 Chronic Pain/Fatigue       Sciatica  
 Degenerative Disc Disease       Other Bone, Joint or Muscle Condition not listed  
 Fibromyalgia  
 Herniated Disc  
 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.

**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
- Specialist
- Chiropractor
- Other healthcare provider or medical facility
- Counselor/Therapist
- Physical Therapist
- Psychiatrist/Psychologist
- 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
- Treatment
- Supplement
- 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
- Prostate Exam
- Breast Exam
- Pulmonary Test
- Colonoscopy
- Skin Check
- CT Scan
- Stress Test
- Echocardiogram
- Ultrasound
- EKG/ECG
- Urinalysis
- Mammogram
- X-Ray
- MRI
- Other
- Pap Smear
- 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
- Specialist
- Chiropractor
- Other healthcare provider or medical facility
- Counselor/Therapist
- Physical Therapist
- Psychiatrist/Psychologist
- 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
- Treatment
- Supplement
- 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
- Prostate Exam
- Breast Exam
- Pulmonary Test
- Colonoscopy
- Skin Check
- CT Scan
- Stress Test
- Echocardiogram
- Ultrasound
- EKG/ECG
- Urinalysis
- Mammogram
- X-Ray
- MRI
- Other
- Pap Smear
- 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)