

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.

<p>Applying for:</p> <input type="checkbox"/> New Application <input type="checkbox"/> Existing Policy Change/Reinstatement Policy Number <input type="text"/>	<p>Type of Coverage:</p> <input type="checkbox"/> Disability Income <input type="checkbox"/> Overhead Expense <input type="checkbox"/> DI Retirement Security <input type="checkbox"/> Business Loan Expense <i>If applying for multiple products with different policy owners, separate applications are required.</i>
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▶ PROPOSED INSURED INFORMATION

Name (First, Middle, Last, Suffix) Gender Male Female

Birth Date (mm/dd/yyyy) Social Security Number Birth State/Country Driver's License Number State Issued

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

City State Zip Phone Number Is this a mobile number? Yes No

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 Underwriting 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 include: 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 Principal for this coverage.

<u>Electronic Fund Transfer (EFT)</u>	<u>Check</u>
<input type="checkbox"/> Annual	<input type="checkbox"/> Annual
<input type="checkbox"/> Semi-Annual	<input type="checkbox"/> Semi-Annual
<input type="checkbox"/> Quarterly	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Monthly	

If preferred payment method is EFT, Payment Authorization for Electronic Fund Transfer form 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	\$ <input type="text"/>
Elimination Period	<input type="checkbox"/> 60 day <input type="checkbox"/> 90 day <input type="checkbox"/> 180 day <input type="checkbox"/> 365 day
Benefit Period	<input type="checkbox"/> 2 year <input type="checkbox"/> 5 year <input type="checkbox"/> to Age 65 <input type="checkbox"/> to Age 67 <input type="checkbox"/> to Age 70
True Own Occupation Definition of Disability	<input type="checkbox"/> Total disability while not working in your own occupation

Riders

Increase Options (choose one)	<input type="checkbox"/> Annual Increase <input type="checkbox"/> Annual Increase and Maximize Your Benefit (Annual Increase rider is required with Maximize Your Benefit rider)
Capital Sum Benefit	<input type="checkbox"/>
Catastrophic Disability Benefit	\$ <input type="text"/>
Cost of Living Adjustment	<input type="checkbox"/> 3% <input type="checkbox"/> 6%
Death Benefit	<input type="checkbox"/>
Mental Nervous and Substance Abuse Limitation	<input type="checkbox"/> (required in some states and for certain occupations, not available in VT)
Residual coverage options (choose one)	<input type="checkbox"/> Residual Disability & Recovery Benefit <input type="checkbox"/> Short Term Residual Disability Benefit <input type="checkbox"/> 6 months or <input type="checkbox"/> 12 months
Supplemental Health Benefit	<input type="checkbox"/>

Additional coverage options available on next page

▶ COVERAGE APPLYING FOR OR REQUESTING TO CHANGE/REINSTATE (Continued)

DI Retirement Security

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

Monthly Benefit Amount	\$ <input type="text"/>
Elimination Period	<input type="checkbox"/> 180 day <input type="checkbox"/> 365 day
Benefit Period	<input type="checkbox"/> to Age 65 <input type="checkbox"/> to Age 67

Riders

Annual Increase	<input type="checkbox"/>
Cost of Living Adjustment	<input type="checkbox"/> 3% <input type="checkbox"/> 6%
Mental Nervous and Substance Abuse Limitation	<input type="checkbox"/> (required in some states and for certain occupations, not available in VT)

A completed Declaration of Trust form is required with this application

Overhead Expense

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

Monthly Benefit Amount	\$ <input type="text"/>
Elimination Period	<input type="checkbox"/> 30 day <input type="checkbox"/> 60 day <input type="checkbox"/> 90 day
Benefit Period	<input type="checkbox"/> 12 months <input type="checkbox"/> 18 months <input type="checkbox"/> 24 months

Riders

Increase Options (choose one)	<input type="checkbox"/> Annual Increase <input type="checkbox"/> Benefit Increase
Residual Disability & Recovery Benefit	<input type="checkbox"/>

A completed Overhead Expense/Business Loan Expense supplement form is required with this application.

Business Loan Expense

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

Monthly Benefit Amount	\$ <input type="text"/>
Elimination Period	<input type="checkbox"/> 30 day <input type="checkbox"/> 60 day <input type="checkbox"/> 90 day <input type="checkbox"/> 180 day
Termination Date	<input type="text"/> month <input type="text"/> day <input type="text"/> year

A completed Overhead Expense/Business Loan Expense supplement form is 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
				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Details (indicate policy change/reduction details)

Replacing/Changing Coverage: *By signing Part C of this application, the Proposed Insured agrees to terminate the insurance policy(s) indicated above as being replaced within 75 days of the acceptance of this policy. Signing indicates the Proposed Insured understands that by not canceling 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)

This ownership designation is applicable to the products selected on page one.

Individual Owner Name (First, Middle, Last, Suffix) **Social Security Number** **Birth Date** (mm/dd/yyyy)

Primary Residence Street Address (Cannot be P.O. Box) **City** **State** **Zip**

Phone Number **Email Address**

Relationship to Proposed Insured: Spouse Parent Sibling Domestic Partner Business Partner Other

Organization Owner Name (Full legal name) **Employer Identification Number**

Primary Headquarters Street Address (Cannot be P.O. Box) **City** **State** **Zip**

Phone Number **Email Address**

To assign benefits to an Individual or Organization which is not the Policy Owner, submit an Assignment of Policy Benefits form to designate a Beneficiary or Loss Payee.

▶ POLICY CHANGE / REINSTATEMENT: DESCRIPTION OF CHANGES

Agreement/Authorization to Obtain and Disclose Information on the Proposed Insured

("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) 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 Owner.

Limitation of Authority: I understand and agree that no financial professional, 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.

- This application is Cash on Delivery; and no Conditional Receipt coverage is provided.
- I have paid \$ as an advance premium with this application which is no less than one month's advance premium and I have been given the Conditional Receipt. In return I have read, understand, and agree to its terms.

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Agreement/Authorization to Obtain and Disclose Information on the Proposed Insured

AUTHORIZATION:

I authorize any medical professional, hospital, clinic, laboratory, pharmacy, pharmacy benefit manager, electronic health record provider, insurance company, reinsuring company, or any other similar person or organization to disclose information about me, to the Company, its reinsurers, and any other party acting on the Company's behalf. Health information includes (a) my entire medical history or records and prescription history; (b) confidential information related to Human Immunodeficiency Virus (HIV), mental health information (excluding psychotherapy notes); (c) genetic information and genetic test results; and (d) alcohol and drug abuse and treatment information to the extent permitted by law. I understand that other authorizations may need to be signed by me to authorize the release of information from specific providers. I understand that if I refuse to sign an authorization to release my complete medical record, the Company may not be able to process my application for life insurance coverage.

I authorize any consumer reporting agency, government agency, agent, CPA, attorney, personal banker, licensed insurance agent, broker, representative, or any other similar organization or person having personal information regarding me to provide such data to the Company, its reinsurers, and any other party acting on the Company's behalf.

I understand that the data obtained by use of this authorization will be used by the Company to determine eligibility and risk classification for insurance.

I authorize any information gathered during the evaluation of my application may be disclosed to MIB, LLC, the Company's reinsurers, and authorized representatives of the Company relating to my application or claims.

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 reinsurers, or any MIB, LLC-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.

This authorization shall be valid for 24 months from the date of this application, unless an earlier date is required by applicable law in the state where the policy is delivered or issued for delivery. I may revoke this authorization for information not then obtained. Such revocation must be in writing. It will not be effective until received at the Company's Home Office. I agree a photocopy of this authorization is as valid as the original. I have received a copy of this authorization. I have received a copy of the "Notice of Insurance Information Practices," which describes the underwriting process, investigative consumer reports and MIB, LLC.

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

Signature of Proposed Insured	Signed at: City	State	Date (mm/dd/yyyy)
X			

Signature of Owner (If other than Proposed Insured)	Signed at: City	State	Date (mm/dd/yyyy)
X			

Signature of Financial Professional	License Number	Date (mm/dd/yyyy)
X		

Printed Name of Financial Professional

Agreement/Authorization to Obtain and Disclose Information on the Proposed Insured

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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) 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 Owner.

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AUTHORIZATION:

I authorize any medical professional, hospital, clinic, laboratory, pharmacy, pharmacy benefit manager, electronic health record provider, insurance company, reinsuring company, or any other similar person or organization to disclose information about me, to the Company, its reinsurers, and any other party acting on the Company's behalf. Health information includes (a) my entire medical history or records and prescription history; (b) confidential information related to Human Immunodeficiency Virus (HIV), mental health information (excluding psychotherapy notes); (c) genetic information and genetic test results; and (d) alcohol and drug abuse and treatment information to the extent permitted by law. I understand that other authorizations may need to be signed by me to authorize the release of information from specific providers. I understand that if I refuse to sign an authorization to release my complete medical record, the Company may not be able to process my application for life insurance coverage.

I authorize any consumer reporting agency, government agency, agent, CPA, attorney, personal banker, licensed insurance agent, broker, representative, or any other similar organization or person having personal information regarding me to provide such data to the Company, its reinsurers, and any other party acting on the Company's behalf.

I understand that the data obtained by use of this authorization will be used by the Company to determine eligibility and risk classification for insurance.

I authorize any information gathered during the evaluation of my application may be disclosed to MIB, LLC, the Company's reinsurers, and authorized representatives of the Company relating to my application or claims.

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 reinsurers, or any MIB, LLC-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.

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AGREEMENT/AUTHORIZATION – Give to Proposed Insured