Principal Financial Group

Principal Life Insurance Company | ***Health Statement – PA***

Account number

Employee Information: After completed make a copy of Page 1, Page 2 and Page 3 for your records.

Your name (last, first, middle initial) | Home phone number | Social security number

Home address (street)

City | State | ZIP code

Date of birth | Company name

Notice of Information Practices for Life and Disability Coverages

In order to properly underwrite and consider your request for coverage, we must collect information to determine if you (and your dependents if also requesting dependent coverage) qualify for insurance with Principal Life Insurance Company. We will do this by having you complete this Health Statement. In addition, we may contact sources besides yourself for personal data about any proposed insured, including (a) spouse, (b) employer, (c) medical professionals or institutions, and (d) insurance companies to which you may have applied for insurance in the past. The personal data may include age, medical history, job, income, habits and other personal characteristic information. We may also ask that medical exams or other tests be completed.

We will keep your data confidential. Only employees performing business transactions regarding your coverage will see your data. In certain circumstances, we may provide data to (a) government agencies, (b) attending physicians, (c) insurance organizations without identification, and (d) the employer, if applicable, for the purpose of reporting claims experience or conducting audits.

You or your dependents, if applicable, have certain rights in connection with this request for coverage. Those rights are:

1. to find out what personal information is contained in Principal Life files (medical information may be disclosed only to your attending physician).
2. to correct or amend information in Principal Life files.

Upon written request, Principal Life will furnish to you (or your dependent) information concerning:

1. the nature and scope of personal data in our records;
2. the types of disclosures which may be made; and
3. rights of access to the information collected and how such information may be corrected or amended.

We will respond to such written request within 30 days from the date of receipt.

For further information about your file or rights, you may contact: Group Operations, Medical Underwriting, Principal Life Insurance Company, Des Moines, IA 50392-0432.

Health Information for All Coverages Being Applied for

Answer only for those individuals requesting coverage. To prevent delays answer each question and give full details to "yes" answers. All statements and descriptions on this form shall be deemed to be representations and not warranties.

Employee's height ____ ft. ____ in. weight _____ lbs. Spouse's height ____ ft. ____ in. weight _____ lbs.

1.	☐ yes ☐ no	Is any person on whom coverage is requested currently using tobacco products, including cigarette, pipe, cigar or chewing tobacco? If so, how long? _____ Which applicant(s)? _____
2.	☐ yes ☐ no	Is any person on whom coverage is requested **currently** receiving medical treatment, taking medication, or pregnant?
3.	☐ yes ☐ no	**In the past 5 years,** has any person on whom coverage is requested had surgery, been hospitalized or consulted with a doctor, had blood or other diagnostic tests (other than for HIV antibody), or been advised to receive medical treatment?
4.	☐ yes ☐ no	**In the past 5 years,** has any person on whom coverage is requested been diagnosed with or received treatment for any of the following (check all that apply)? ☐ cancer ☐ liver disorder ☐ bone disorder ☐ mental disorder ☐ tumors ☐ kidney disorder ☐ joint disorder ☐ nervous disorder ☐ heart condition ☐ muscle disorder ☐ urinary disorder ☐ diabetes ☐ high blood pressure ☐ multiple sclerosis/ neurological disorder ☐ respiratory disorder ☐ hepatitis ☐ stroke
5.	☐ yes ☐ no	**In the past 10 years,** has any person on whom coverage is requested been treated for, diagnosed as having or tested positive for Acquired Immune Deficiency Syndrome (AIDS), AIDS-Related Complex (ARC), or any other immune disorder?

Provide details for all "yes" answers. If more space is needed, attach a separate page giving full details. Sign and date all pages.

Name | Date diagnosed/treated | Duration of illness or condition

Diagnosis of illness or condition | Type of treatment/names of all medications

Any current symptoms or problems

Names and addresses of doctors, hospitals or other providers

Name | Date diagnosed/treated | Duration of illness or condition

Diagnosis of illness or condition | Type of treatment/names of all medications

Any current symptoms or problems

Names and addresses of doctors, hospitals or other providers

Name | Date diagnosed/treated | Duration of illness or condition

Diagnosis of illness or condition | Type of treatment/names of all medications

Any current symptoms or problems

Names and addresses of doctors, hospitals or other providers

Authorization, Acknowledgment, and Signatures

- I represent information, statements, and answers on this form, and any attachments, are complete and true to the best of my knowledge. They are a part of this request for coverage under the group policies. I agree Principal Life is not liable for anyone's claim which happens or begins before the effective date of coverage or approval of any life and disability coverage.
- I have read, or had read to me, the questions and responses and realize any false statements, omissions or material misrepresentation regarding age or health information could cause life and disability coverages, if issued, to be cancelled as never effective.
- Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.
- I understand all policy provisions for medical coverage will apply. If approved for life and disability coverages, all policy provisions will apply including, but not limited to, preexisting conditions restriction, the Actively at Work and Period of Limited Activity provisions.
- I understand an agent cannot change or waive any rates, benefits, or provisions of any policy, if issued, without the written approval of an officer of Principal Life.
- For life and disability coverages, I authorize any doctor, health care provider, hospital, clinic or medically related facility, insurance company, consumer reporting agency or employer, that has any personal information, including physical, mental, drug or alcohol use history, regarding me or any dependent, to give to Principal Life, its agents and employees performing business transactions, any such data.
- For medical coverage, I authorize pharmacy benefit managers, “health care providers”, and entities covered under the HIPAA Privacy Rule and their agents and employees, to disclose my personal health information to Principal Life, its agents, and employees, for purposes of underwriting my application for coverage, and making eligibility, premium rating, and enrollment decisions, relating to any coverage I have, have applied for, or may in the future apply for with Principal Life. This includes information concerning the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection, sexually transmitted diseases, mental illness, and the use of alcohol, drugs, and tobacco. This authorization shall remain in force for two years following the date of my signature. I may revoke this authorization in writing at any time by sending the request for revocation to: Health Information Protection Analyst, Group Compliance, Principal Life Insurance Company, Des Moines, IA 50392-0302. A revocation is not effective if Principal Life has relied on the protected health information disclosed to it. Any information disclosed under this authorization may no longer be covered by privacy provisions of HIPAA and may be subject to redisclosure. I understand that if I refuse this authorization, Principal Life may not make an eligibility determination, and I will not be considered for coverage with Principal Life. I have read and I understand this authorization.
- I authorize Principal Life to release any such data as required by law. When signed in connection with any application for, reinstatement of, or request for change in benefits, this form shall be valid for two years after the date shown below. I understand I may revoke this authorization for information not then obtained. A photocopy of this form shall be as valid as the original.
- I understand the data obtained by use of this authorization will be used by Principal Life for claims administration and to determine eligibility for life and disability coverage. This information will not be used for any purposes prohibited by law.

Employee’s signature	Date signed
Spouse’s signature*	Date signed

*Spouse signature only required if Voluntary Term Life coverage is elected.