Principal Financial Group

Mailing address:
P.O. Box 4934
Grand Island, NE 68802

Principal Life Insurance Company

Statement of Health - FL

PLEASE USE BLACK INK
PLEASE ENTER DATES AS MM/DD/YYYY

Collective Group Underwriting and Late Enrollees Application ONLY
(Also for use when requesting life coverage over the guaranteed issue amount)

Account number

Instructions

1. The Employee Information section should always be completed with the information about the employee.
2. The employee must ALWAYS sign the last page of this form.
3. When coverage is being requested for an eligible dependent(s), note that this form applies to all persons requesting coverage.
   a. Complete the Eligible Dependent Information section, if applicable.
   b. Complete the Health Information section for you and your eligible dependents, if applicable.
   c. The spouse or domestic partner must sign the last page of this form if spouse or domestic partner coverage is being requested.
4. After completing and signing this form, make a copy for your records.

Why is this Statement of Health being submitted?

☐ over the Guaranteed Issue amount ☐ late entrant (request made outside the eligibility period)

Employee Information

Your name (last, first, middle initial)	Gender ☐ male ☐ female	Social security number	Date of birth
Home address (street)			
City	State		ZIP code
Home phone number	Company name		

Eligible Dependent Information

Name (last, first, middle initial)	Gender	Social security number	Date of birth
	☐ male ☐ female		
	☐ male ☐ female		
	☐ male ☐ female		
	☐ male ☐ female		
	☐ male ☐ female		
	☐ male ☐ female		
	☐ male ☐ female		

If additional dependents, list on separate page. Please sign and date the separate page.

Health Information **120**

To prevent delays give full details to "yes" answers for everyone requesting coverage. You do not have to reveal additional details regarding HIV/AIDS/ARC treatment or testing. If more space is needed, attach a separate page giving full details. Sign and date all those pages.

1. **Employee's height** ___ ft. _____ in. **weight** _____ lbs.
   Spouse's or domestic partner's height ___ ft. _____ in. **weight** _____ lbs.

2. ☐ yes ☐ no — Is any person receiving medical treatment by a licensed provider or taking medication as prescribed by a licensed provider?

3. ☐ yes ☐ no — To the best of your knowledge and belief, is any person currently pregnant?

4. ☐ yes ☐ no — **In the past 5 years,** has any person had surgery, been hospitalized or consulted with a physician or medical practitioner, or had blood or other diagnostic tests (other than for HIV antibody)? Provide results of all tests.

5. ☐ yes ☐ no — **In the past 5 years,** has any person been diagnosed with or received treatment by a licensed provider for any of the following (check all that apply)?

☐ cancer	☐ liver disorder	☐ bone/joint disorder	☐ psychological/ mental disorder
☐ tumor(s)	☐ kidney/urinary disorder	☐ respiratory disorder	
☐ heart or circulatory disorder	☐ muscle disorder	☐ infertility	☐ blood disorder
	☐ multiple sclerosis/ neurological disorder	☐ skin/eyes/ear/nose /throat disorder	☐ hepatitis
☐ stroke			☐ organ or other transplants
☐ alcohol/drug use	☐ digestive disorder	☐ gland disorder	

☐ High blood pressure – last reading and date _____ / _____

☐ Diabetes – last HbA1c reading and date _____ / _____

☐ Other – including medication _____

6. ☐ yes ☐ no — In the last ten years, has anyone tested positive for exposure to the HIV infection or been diagnosed as having ARC or AIDS caused by the HIV infection or other sickness or condition derived from such infection?

If applying for Critical Illness, complete question 7.

7. ☐ yes ☐ no — To the best of your knowledge and belief, have any of your natural parents, brothers or sisters been diagnosed with coronary artery disease, stroke, diabetes or invasive cancer prior to age 55?

   Employee – if yes, disease and age at diagnosis: _____

   Spouse or domestic partner – if yes, disease and age at diagnosis: _____

Provide details for all "yes" answers. You do not have to reveal additional details regarding HIV/AIDS/ARC treatment or testing. If more space is needed, attach a separate page giving full details. Sign and date all those pages.

Name	Date diagnosed/treated	Length of illness or condition

Diagnosis of illness or condition	Type of treatment, including medications

Describe current symptoms or problems

Names of all current medications

Names and addresses of physicians, medical practitioners, hospitals or other health care providers

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Names of all current medications		
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Print

Notice of Information Practices 120

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 Statement of Health. In addition, we may contact sources besides yourself for personal data about any proposed insured, including (a) spouse or domestic partner, (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, (d) the employer, and (e) our reinsurer, 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, Group Medical Underwriting, Principal Life Insurance Company, 711 High Street, Des Moines, IA 50392-0531.

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 and approval of 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 coverage, if issued, to be cancelled as never effective.
- If approved for coverage, 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.
- I authorize any physician, medical practitioner, 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, employees or reinsurers performing business transactions, any such data.
- 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 at any time. The request for revocation must be in writing and sent to: Group Operations, Medical Underwriting, Principal Life Insurance Company, 711 High Street, Des Moines, IA 50392-0531. I understand that a revocation is not effective if Principal Life 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 coverage under the policy itself. 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 coverage. This information will not be used for any purposes prohibited by law.
- Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Employee's signature	**Date signed**
X	
Spouse's or domestic partner's signature	**Date signed**
X	