



Mailing Address: Des Moines, IA 50392-0001

Principal Life Insurance Company Insurance Application

Proposed Insured _____
Date of Birth ___ / ___ / _____ Policy Number (If known) _____

PART B - (Continued)

INCOME/OCCUPATION

For Life, complete questions 7 and 8. For DI, complete questions 7-17. In all cases, Part B continues on the next page.

7. Primary occupation _____ Employer _____
8. Annual income from occupation \$ _____ Other Income \$ _____
Source of other income _____ Net Worth (Assets - Liabilities) \$ _____
9. Current Employment Information
a. Type of business or industry _____
b. Job title _____
c. What are your job activities and percentage of time spent in each? _____
d. How many hours do you usually work per week in your primary job? _____
e. Total number of employees: Full-time _____ Part-time _____ Sub-contracted _____
f. How many employees do you supervise? _____
10. How long have you been employed by your current employer? _____ (If less than three years, provide details below, e.g., employers, occupations and dates for last five years.)
11. Do you work out of your home? (If yes, how many hours per week? _____) Yes No
12. Do you have any other part-time or full-time jobs? (If yes, explain below) Yes No
13. Are you actively at work on a full-time basis without medical restriction? (If no, explain below) Yes No
14. Do you intend to change jobs or employment in the next 6 months? (If yes, explain below) Yes No
15. Have you ever requested or received any type of disability benefits (including worker's compensation and state disability) for an injury or illness? (If yes, explain below)..... Yes No
16. Do you have an ownership interest in any business you work for? Yes No
If yes, ownership percentage _____ length of ownership _____
Type of business: C Corporation S Corporation Partnership
 Sole Proprietorship Limited Liability Company Other _____
17. Have you, or any business owned in whole or part by you, ever been in bankruptcy or any similar proceedings? (If yes, provide date discharged, type and chapter)..... Yes No

DETAILS TO QUESTIONS 7-17

Table with 2 columns: Quest. #, Include dates and details as requested above.



Mailing Address:
Des Moines, IA 50392-0001

Principal Life
Insurance Company

Disability Buy-Out
Application Supplement

1. Proposed Insured _____ Date of Birth _____

2. Name of your business _____ Date organized/purchased _____

Benefits:

- Elimination Period: 365 day, 540 day, 730 day
Benefit Period Factor: 24, 36, 60
Lump Sum - Benefit Amount \$
Monthly Payments - Monthly Amount \$
Combination Method (Complete Lump Sum and Monthly Payment Items above)

Optional Benefit Riders:

- Benefit Update
Other _____

Owner (Must be other than the proposed insured) - (Please list owner and have sign this form and Part C).

Table with 4 columns: Name (Owner), Address, City, State, Zip, Owner Taxpayer ID Number

3. Type of business: Partnership, C-Corp, S-Corp, Limited Liability Company (LLC)

4. Your percent of ownership _____ %

5. Number of employees: full time, part time, subcontracted

6. Average number of hours worked per week for the firm _____

7. Has your firm or any of its principals declared bankruptcy in the last 5 years? Yes No
If Yes, explain:

8. Are all full-time active owners applying for Disability Buy-Out insurance? Yes No
If No, explain:

9. Are any owners related? (i.e. parent, child, spouse or sibling) Yes No
If Yes, indicate relationship:

10. List all owners proposed for Disability Buy-Out insurance:

Table with 4 columns: Name, Age, Job Title, % of Ownership

11. Type of Buy-Sell Agreement in force or planned: Cross purchase, Entity purchase, Stock redemption, Other (describe)



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Principal Life
Insurance Company

Disability Buy-Out
Application Supplement

Proposed Insured _____ Policy Number (if known) _____

12. a. Valuation Basis:

Principal Life's underwriting guidelines

Other (i.e. book value, sale of similar business, etc.) _____

b. **TOTAL CURRENT VALUE** based on the method indicated in question 12.a. \$ _____

	Year to Date	Last Tax Year	Prior Tax Year
13. TOTAL OWNERS' SALARIES	\$ _____	_____	_____
14. GROSS ANNUAL RECEIPTS	\$ _____	_____	_____
15. NET ANNUAL PROFIT	\$ _____	_____	_____
16. BOOK VALUE	\$ _____	_____	_____

I represent that all the above statements in this application are true and complete to the best of my knowledge and belief. I understand that the statements in this application are a part of any insurance issued.

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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

SIGNATURES (Please do not print name below. **Signatures are required.**)

X _____
Proposed Insured (Signature) Signed at: City _____ State _____ / _____ / _____
Date

X _____
Witness (Licensed Agent/Broker/Representative) _____ / _____ / _____
Date



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

Individual Disability Insurance Application

Thank you for choosing Principal Life Insurance Company to meet your client's individual disability insurance needs.
Please follow the instructions below to expedite the application process.

General Instructions

- Complete **Part A** of the application and obtain signatures on **Part C**. Answer all questions legibly in blue or black ink. The **applicant** is required to initial any changes.

- Complete the **Producer Report** and all **supplemental forms** (if applicable).

- If utilizing the TeleApp process, please call toll free **1-888-835-3277** (1-888-TELEAPP) to schedule the telephone application interview. A TeleApp counselor will ask the questions from Part B (medical/habits information) of the application.

If using the traditional application process, obtain and complete **PART B** of the application. Answer all questions legibly in blue or black ink. The **applicant** is required to initial any changes. A personal telephone interview (PTI) is also required when using the traditional application process. To schedule the PTI call 1-888-835-3277.

NOTE: The TeleApp Counselor will offer to order Routine Underwriting Requirements for all new applications.

- Association Sales Program applications** require home office pre-approval and a copy of the Association Endorsement letter. If you have an Association, whose members you market disability insurance products to, please contact Jeff Hannemann at 1-800-247-9988, x20992 or Hannemann.Jeff@principal.com for pre-approval.

- Submit the **Producer Report, Part A, Part B** (if applicable), **Part C and all supplemental forms** (if applicable). Please do not duplex the application pages and only print data and wording on one side of a page.

- Submit **verification of income/financial** documentation.

- Submit the **Premium Summary Report** of the DI Illustration. Submitting this report helps expedite the underwriting process.

- If COD (Cash on Delivery) do not give the **Conditional Receipt** to the applicant/proposed insured. If money is taken with the application or if the pre-approved Payroll Deduction Form (Applicable to Multi-Life cases only) is used, then give the Conditional Receipt to the applicant/Proposed Insured.



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

Individual Disability Insurance Producer Report

Proposed Insured _____ Policy Number _____

1. Office Contact Information – Whom should we contact during the processing of this application?

Contact Name	Contact's Phone Number	Contact's Email Address
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2. Producer Information

Producer's Office Name	Producer's Principal Office Number	Producer's Phone Number
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3. Compensation Information

List all Producers to Receive Compensation	Tax ID Number	Statement/ Detail Code	Commission Split	
			Selling	Servicing
Primary Servicing Producer				
Enter Signing Producer's Tax ID Number for Corporation or Non-Corporation				

4. Underwriting Requirements (Please check the underwriting requirements that have been ordered)

- TeleApp/Personal Telephone Interview (PTI) Confirmation Number _____
If TeleApp or PTI has not been scheduled, please call 1-888-TeleApp and schedule at this time.
- Is an interpreter required for TeleApp? Yes No If Yes, list language: _____
- HOBP/HOS Ordered through _____
- Urine-HIV Ordered through _____
- Mini/Paramed Ordered through _____
- EKG Ordered through _____
- APS _____ Other _____

5. Additional Information

a. Discounts (check those that apply)

- Multi-Life (List Bill – requires three or more lives)
Employer's Name _____
Employer's Address _____
Employer Tax ID _____
List Bill Number (if known) _____
- Association (If approved in your state)
Association Name _____
Association Number _____
- Mental/Nervous (Not available in Texas)
- Select Occupation

b. Occupation Class Quoted: 5A 5A-M 4A 4A-M 3A 3A-M 2A A

c. Send premium notices to (if other than the policyowner) _____

d. Proposed Insured's relationship to the Producer/Licensed Representative _____



Mailing Address: Des Moines, IA 50392-0001

Principal Life Insurance Company

Disability Insurance Application - PART A

1. PERSONAL INFORMATION ABOUT THE PROPOSED INSURED

Name (First, Middle, Last) Male Female Date of Birth
State of Birth
Street Address (Country, if other than U.S.) Social Security Number
City State Zip Home Phone Number Work Phone Number
Occupation/Duties Drivers License Number State

Have you smoked cigarettes or used a nicotine patch or gum within the past 12 months? Yes No
Are you a U.S. citizen? Yes No

2. INDICATE COVERAGE(S) BEING APPLIED FOR

- Disability Income (Complete Sections 3-7 and Part C)
Overhead Expense (Complete Sections 4-7, Part C, and the Overhead Expense Application Supplement)
Disability Buy-Out (Complete Sections 4-7, Part C, and the Buy-Out Application Supplement)
DI Retirement Security (Complete Sections 4-7, Part C, and the DI Retirement Security Application Supplement)

3. DISABILITY INCOME

Monthly Benefit Amount: \$
Elimination Period: 30 day 60 day 90 day 180 day 365 day
Benefit Period: 2 year 5 year to age 65 to age 67 to age 70
Your Occupation Period: 2 year 5 year to age 65 to age 67 to age 70

Social Insurance Substitute (SIS)
Monthly Benefit: \$ SIS Benefit Period must equal Base Benefit Period.
SIS Elimination Period: 30 day 60 day 90 day 180 day 365 day

Adaptable Income Benefits (AIB)

1st AIB Monthly Benefit: \$ from day to day
2nd AIB Monthly Benefit: \$ from day to day
SIS AIB Monthly Benefit: \$ from day to day

Optional Benefit Riders

- Cost of Living Adjustment 3% max 6% max
Residual Disability Benefit
Short Term Residual Disability Benefit 6 month 12 month
Recovery Benefit 1 year 3 year
Catastrophic Disability Benefit (CDB) Monthly Amount: \$
CDB Elimination Period: 90 day 180 day 365 day
CDB Benefit Period: 2 year 5 year to age 65 to age 67 to age 70
Regular Occupation
Extended Total Disability Benefit
Aggregate Benefit Factor 50 75 100
Other

You MUST select ONE of the following:

- Benefit Update (BU) AND Automatic Increase Option (AIO)
Benefit Update (BU) only
Automatic Increase Option (AIO) only
Neither BU nor AIO



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Principal Life
Insurance Company

Disability Insurance
Application – PART A

Proposed Insured _____ Policy Number (if known) _____

3. DISABILITY INCOME (Continued)

Owner (if other than proposed insured) – (Please list owner below and sign Part C.)

Name		Address		
City	State	Zip	Owner Taxpayer ID Number	

BENEFIT RECIPIENT (if other than owner) FOR DISABILITY INCOME ONLY

Name		Address		
City	State	Zip		

4. PREMIUM PAYER AND METHOD OF PAYMENT

- a. Premium paid by: Individual ____ % Employer ____ %
- b. If your employer pays any part of the premium, is it reportable by you as taxable income? Yes No
- c. Premium Mode: Annual Semi Annual* Quarterly* EFT*
- * There is an additional charge for premium payment frequencies other than annual.

5. OTHER DISABILITY, ACCIDENT AND SICKNESS INSURANCE

Do you have any other Disability, Accident and Sickness Insurance in force or pending?..... Yes No

If Yes, list all Disability income (and list any Catastrophic Disability coverage separately), Overhead Expense, and Buy-Out coverage in force and all coverage(s) applied for in the past 12 months with all companies including disability benefits provided under group, pension, or retirement plans, salary continuation plans, association plans, credit insurance plans, and any other accident, sickness, or health coverage. Also include coverage for which you will become eligible in the next 3 years after a qualifying period of employment has been met. List the type of coverage in force and indicate if it is individual pay (I) or employer pay (E).

Company	Policy No.	Type of Coverage	Benefit Amt. or % of Income	Elim. Period	Benefit Period	Ind. Pay (I) Emp. Pay (E)		Pending		Replacing	
						<input type="checkbox"/> I <input type="checkbox"/> E	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No			
						<input type="checkbox"/> I <input type="checkbox"/> E	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
						<input type="checkbox"/> I <input type="checkbox"/> E	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
						<input type="checkbox"/> I <input type="checkbox"/> E	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
						<input type="checkbox"/> I <input type="checkbox"/> E	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	

Replacement: By signing this application, I agree to terminate the insurance policy(s) that I indicated above as being replaced within 60 days of the acceptance of this policy. I understand that if I do not cancel or lapse the insurance policy(s), Principal Life Insurance Company has the right to rescind (terminate as if never issued) any policy issued as a result of this application.



Mailing Address: Des Moines, IA 50392-0001

Principal Life Insurance Company Disability Insurance Application - PART A

Proposed Insured _____ Policy Number (if known) _____

6. FINANCIAL

- a. Unearned Income - Includes capital gains, interest, dividends, net rental income, pensions, annuities, and alimony. Is unearned income greater than 10% of earned income, or \$30,000?
b. Net Worth - Is net worth, excluding primary residence, greater than \$6,000,000?

Table with 4 columns: Earned Income - Income as shown on Federal Income Tax Return, Current YTD, Last Yr., 2 Yrs Ago. Rows include Owner or Nonowner Employee's salary & bonus, Owner-Employee's share of after-tax corp profits or losses, Sole Proprietor net income, Share of Partnership or LLC net income, Pension plan or Profit-Sharing contributions, and Total Earned Income.

If using Teleapp, answer question 7 below and proceed to Part C (page 8); If using Traditional application process, stop here and proceed to Part B (pages 4-7).

7. MEDICAL QUESTION

- a. Within the last five years, have you been treated for or diagnosed as having a heart condition, chest pain, stroke, back or neck problem, psychological condition...
b. Current Height _____ Weight _____ Have you lost more than 10 lbs. in the last year?

Comments: _____

AGREEMENT/AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

("Company" means Principal Life Insurance Company)

AGREEMENT: Statements In Application: I represent that all statements in this application 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, including all of its parts, and statements by the Proposed Insured in any medical questionnaire that becomes a part of this application, will be the basis of any insurance issued. I understand that material misrepresentations could mean denial of an otherwise valid claim and rescission of the policy during the contestable period.

When Insurance Effective: I understand and agree that the Company shall incur no liability unless: (1) a policy issued on this application has been received and accepted by the owner and the first premium paid; and (2) at the time of such receipt and payment, the person to be insured is actually in the state of health and insurability represented in this application, medical questionnaire, or amendment that becomes a part of this application; and (3) the Part D of the completed Tele-App interview or the Delivery Receipt form is 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.

Limitation of Authority: I understand and agree that no licensed agent, broker or 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 and on any medical questionnaire that becomes a part of this application may not be waived. No knowledge of any fact on the part of any licensed agent, broker or representative, telephone interviewer, medical examiner, or other person shall be considered knowledge of the Company unless such fact is stated in the application.

<input type="checkbox"/> This application is C.O.D. or <input type="checkbox"/> I have paid \$ _____ for Disability Income/ \$ _____ for Overhead Expense/ \$ _____ for Disability Buy-Out insurance, which is no less than one month's advance premium. If money was paid, I have been given the Conditional Receipt. In return I have read, understand, and agree to its terms.

AUTHORIZATION: I authorize any doctor, hospital, clinic, health care provider, pharmacy benefit manager, insurance (or reinsuring) company, consumer reporting agency, licensed insurance agent, broker or representative, or any other organization, institution, or person having personal information (including physical, mental, drug, or alcohol use history) regarding me to provide to the Company, its representatives, or reinsurers, any such data. I authorize the Company to conduct a telephone interview in connection with my application for insurance.

I authorize the Medical Information Bureau, Inc. (MIB, Inc.) to furnish data to the Company or its reinsurers. I authorize Principal Life to release any such data to MIB, Inc. or as required by law. Notwithstanding any other provision in this form, the authorization to release data to the MIB, Inc. shall survive the termination of this form to the extent necessary to confirm, correct, or update previously supplied data to the MIB, Inc. 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, Inc. I agree that this authorization shall be valid for 24 months from the earlier of: (1) the date of this application, or (2) the date of my policy. 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.

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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Pre-Existing Condition Limitation:

The policy being applied for does not cover Disability or loss which begins within two years after the effective date of coverage(s) and results from a pre-existing condition which occurred within the two year period prior to the effective date of coverage(s) and was not disclosed or was misrepresented in this application.

SIGNATURES (Please do not print name below. Signatures are required.)

X	Proposed Insured (Signature)	Signed at: City _____ State _____ Date ____/____/____
X	Disability Income; Owner of Insurance (If other than Insured)	Title (If Corporation, Officer other than the Proposed Insured) _____
X	Overhead Expense; Owner of Insurance (If other than Insured)	Title (If Corporation, Officer other than the Proposed Insured) _____
X	Disability Buy-Out; Owner of Insurance (If other than Insured)	Title (If Corporation, Officer other than the Proposed Insured) _____
X	Licensed Agent/Broker/Representative (Signature)	License Number _____ Date ____/____/____
X	Co-signature by Resident Lic. Agent/Broker/Rep. (if applicable in your state)	License Number _____ Date ____/____/____



Mailing Address:
Des Moines, IA 50392-0001

Principal Life Insurance Company | Disability Insurance Application – PART C

AGREEMENT/AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

("Company" means Principal Life Insurance Company)

AGREEMENT: Statements In Application: I represent that all statements in this application 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, including all of its parts, and statements by the Proposed Insured in any medical questionnaire that becomes a part of this application, will be the basis of any insurance issued. I understand that material misrepresentations could mean denial of an otherwise valid claim and rescission of the policy during the contestable period.

When Insurance Effective: I understand and agree that the Company shall incur no liability unless: (1) a policy issued on this application has been received and accepted by the owner and the first premium paid; and (2) at the time of such receipt and payment, the person to be insured is actually in the state of health and insurability represented in this application, medical questionnaire, or amendment that becomes a part of this application; and (3) the Part D of the completed Tele-App interview or the Delivery Receipt form is 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.

Limitation of Authority: I understand and agree that no licensed agent, broker or 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 and on any medical questionnaire that becomes a part of this application may not be waived. No knowledge of any fact on the part of any licensed agent, broker or representative, telephone interviewer, medical examiner, or other person shall be considered knowledge of the Company unless such fact is stated in the application.

This application is C.O.D. or I have paid \$ _____ for Disability Income/
\$ _____ for Overhead Expense/ \$ _____ for Disability Buy-Out insurance,
which is no less than one month's advance premium. If money was paid, I have been given the Conditional Receipt. In return I have read, understand, and agree to its terms.

AUTHORIZATION: I authorize any doctor, hospital, clinic, health care provider, pharmacy benefit manager, insurance (or reinsuring) company, consumer reporting agency, licensed insurance agent, broker or representative, or any other organization, institution, or person having personal information (including physical, mental, drug, or alcohol use history) regarding me to provide to the Company, its representatives, or reinsurers, any such data. I authorize the Company to conduct a telephone interview in connection with my application for insurance.

I authorize the Medical Information Bureau, Inc. (MIB, Inc.) to furnish data to the Company or its reinsurers. I authorize Principal Life to release any such data to MIB, Inc. or as required by law. Notwithstanding any other provision in this form, the authorization to release data to the MIB, Inc. shall survive the termination of this form to the extent necessary to confirm, correct, or update previously supplied data to the MIB, Inc. 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, Inc. I agree that this authorization shall be valid for 24 months from the earlier of: (1) the date of this application, or (2) the date of my policy. 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.

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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

We appreciate your 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 and any named dependents. 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, job, 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, job, income, habits, hobbies and other personal characteristics. We may contact other sources for personal data, including: (1) spouse, (2) roommate, (3) accountant, (4) lawyer, (5) employer, (6) other persons who know you well, (7) insurance companies to which you may have applied for insurance in the past and (8) MIB, Inc. 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 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 will attempt to keep your data confidential. It will be seen only by employees and agents of Principal Life Insurance Company who underwrite and administer your coverage. We may also provide data to: (1) MIB, Inc.; (2) other insurance companies, if you authorize release of the data to them; (3) our reinsurers, if needed to secure reinsurance; (4) federal and state agencies and others if required by law; (5) our research personnel (anonymously) to help market our products.

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. We will respond to your first request within 30 days from the date of receipt. You may be charged a fee for any copies of your data. Medical data will be disclosed to a doctor of your choice, unless you instruct us to send the medical data directly to you. (Medical information received from doctors and other health care providers may be prohibited from redisclosure.) You have the right to see your nonmedical data and obtain a copy. You have the right to correct or amend any data in your file. Any request for correction or amendment must be in writing. If we agree with you, we will notify anyone we may have given such incorrect data. We will also delete data from your file if we agree it is incorrect. If we disagree with your correction or amendment, we will give you our reason. You may respond in writing listing the basis on which you dispute the correctness of the data. Your response will be added to your file.

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: Underwriting Officer, Principal Life Insurance Company, Des Moines, Iowa 50392-1620 (Telephone 515-247-5141).

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 Medical Information Bureau, a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the Bureau, upon request, will supply such company with the information in its file.

Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the Bureau’s file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of the Bureau’s information office is P.O. Box 105, Essex Station, Boston, Massachusetts 02112, telephone number (617) 426-3660.

With your authorization, Principal Life Insurance Company, or its reinsurers, may also release information in its file to other insurance companies to whom you apply for life or health insurance, or to whom a claim for benefits may be submitted.



Mailing Address:
Des Moines, IA 50392-0001

Principal Life
Insurance Company

Disability Insurance
Conditional Receipt

(In this Receipt, "we", "us", "our", or "the Company" is Principal Life Insurance Company.)

Name of Proposed Insured

Advance payment of: (Disability Income)	(Overhead Expense)	(Disability Buy-Out)
\$ _____	\$ _____	\$ _____
has been received this date as a premium deposit with the application bearing the same date as this Receipt.		
Licensed Agent/Broker/Representative		Date of Receipt
_____		____ / ____ / ____

AUTHORITY:

This Receipt does not create any temporary or interim insurance. However, it does set the date when the insurance under the policy applied for will become effective if all required conditions are met. No licensed agent, broker or representative, medical examiner, or telephone interviewer may accept risks, determine insurability, or bind the Company in any way. No licensed agent, broker or representative may waive or change any terms of the Receipt, or of the policy(ies) applied for, or any other rights of the Company.

The licensed agent, broker or representative has **NO AUTHORITY** to accept any premium or to issue this Receipt: 1) if it is apparent that any **Condition Precedent** to coverage under this Receipt is not or cannot be satisfied; 2) in the case of an application for Disability Buy-Out insurance. **This Conditional Receipt shall be ineffective if issued without authority. Only the Home Office, and not the licensed agent, broker or representative, has authority to modify any provisions of this Receipt.**

WHEN THE INSURANCE WILL BECOME EFFECTIVE:

If all of the **Conditions Precedent** set forth in this Receipt are fulfilled exactly, insurance under the terms of the policy, subject to the Limitations set forth in this Receipt, will take effect on the **Start Date**. The **Start Date** is the date upon which all of our initial application requirements are completed. Our initial application requirements consist of full completion and signing of the application (Parts A and C, if using the telephone application process; Parts A, B, & C, if using the paper application process) and all necessary supplements, and any initially required medical exams and tests required by our then current underwriting guidelines and practices.

DATE USED TO DETERMINE INSURABILITY:

We will determine the insurability of the proposed insured as of the **Start Date**. We have until the actual delivery of the policy to make this determination, but we will not consider changes in the proposed insured's health or insurability that occur after the **Start Date**. If an event giving rise to a claim occurs at any time before physical delivery and acceptance of a policy by the owner, benefits payable for such claim are subject to all of the Limitations set forth in this Receipt. If an event giving rise to a claim occurs at any time after physical delivery and acceptance of the new policy by the owner, the claim will be considered solely under the policy. If any provision of this Receipt is unenforceable under state law, all other terms and conditions shall continue in full force and effect.

--CONTINUED--

CONDITIONS PRECEDENT:

All the following conditions must be fulfilled exactly before any insurance becomes effective.

1. Full completion and signing of the application and all necessary supplements and all initially required medical exams and tests have been completed within 60 days of the date of this Receipt.
2. On the **Start Date**, the Proposed Insured must be insurable, as determined by our underwriters under our then current underwriting guidelines and practices. If a condition affecting such insurability existed in fact on the **Start Date**, it shall be considered in the determination of insurability.
3. The premium deposit must be at least one full month's premium for each policy applied for.
4. The premium deposit must be paid at the time the application is signed, and this Receipt must be issued at the same time.
5. The premium deposit must be received in our Home Office and must be honored on first presentation for payment.

LIMITATIONS:

1. Except as limited by this Receipt, our liability is governed by the terms of the policy(ies) applied for.
2. No benefit is payable and this Receipt is void if there is any incorrect, untrue, incomplete, or omitted statement of material fact in Part A, B, or C of the application, any supplemental form, or medical questionnaire that becomes a part of the policy. Subject to the Time Limit on Certain Defenses provision in the policy, no knowledge of any fact on the part of any licensed agent, broker or representative, medical examiner, telephone interviewer, or other person shall be considered knowledge of the Company unless such fact is stated in the application.
3. If a policy is not issued within 75 days of the **Start Date**, the application will be deemed rejected, all premium will be refunded to the premium payer, and a notice will be sent to the proposed owner that no policy will be issued on the application.
4. **Disability Income, Catastrophic Disability Benefit, or Overhead Expense Insurance** – For any claim that occurs at any time after the **Start Date** and before physical delivery and acceptance of a policy by the owner, any Disability Income, Catastrophic Disability Benefit, or Overhead Expense maximum monthly benefit payable will be the lesser of:
 - The amount of benefits applied for in the application;
 - The amount of benefits that would be offered subject to our then current underwriting guidelines and practices; or
 - \$5,000 (Disability Benefit and Social Insurance Substitute Benefit); \$5,000 (Overhead Expense Benefit); \$2,500 (Catastrophic Disability Benefit).

If the owner refuses physical delivery of the policy, no benefit is payable and this receipt is void. Any premium paid for the policy will be refunded to the premium payer.

5. There is no Conditional Receipt coverage for Disability Buy-Out insurance.

PREMIUMS:

If a policy is issued from this application and the policy is accepted by the proposed owner, we will apply the premium deposit to the first premium due for such policy. If no policy is put in force the premium deposit will be refunded to the premium payer. If this Receipt is issued for more than one type of insurance, the provisions of this paragraph shall apply separately with respect to each type.

ALL PREMIUM CHECKS MUST BE MADE PAYABLE TO PRINCIPAL LIFE INSURANCE COMPANY – DO NOT MAKE CHECKS PAYABLE TO THE LICENSED AGENT/BROKER/REPRESENTATIVE OR LEAVE THE PAYEE BLANK.



Mailing Address:
Des Moines, IA 50392-0001

**Principal Life
Insurance Company**

***Disclosure of
Compensation Information***

As a result of this sale, your Principal Life representative (or his/her firm) may receive compensation (cash or otherwise) that is based in part on factors such as total deposits, assets or premium volume and persistency or profitability of the business he/she sells. The cost of this compensation may be directly or indirectly reflected in the premium or fee for this product. The representative may receive this compensation from the insurer and/or entities through which he/she places business. Please contact your Principal Life representative if you have any questions about this compensation.

If you pay compensation directly to your Principal Life representative, he/she will provide you with a separate Disclosure of Compensation Information Form that provides additional information on the compensation he/she may receive.



Mailing Address:
Des Moines, IA 50392-0002

Principal Life
Insurance Company

Authorization for Release of Personal Health Information - All States
(Applicable to Individual Life and Disability Insurance Customers)

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 Principal Life Insurance 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 Principal Life. 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 unless prohibited by state and/or federal law the protected health information is to be disclosed under this authorization so that Principal Life 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 Principal Life. *Statement required by §164.508(c)(1)(iv).*

The following groups of persons employed or working for Principal Life may use my personal health information which is described above: employees of the underwriting, administration, claim or legal departments and any other personnel of Principal Life, 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 Principal Life. *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, Des Moines, IA 50392-1780. 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 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, Principal Life 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.

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).*



Mailing Address:
Des Moines, IA 50392-0002

**Principal Life
Insurance Company**

**Authorization for Release of Personal
Health Information - All States**
*(Applicable to Individual Life and Disability
Insurance Customers)*

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 Principal Life Insurance 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 Principal Life. 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 unless prohibited by state and/or federal law the protected health information is to be disclosed under this authorization so that Principal Life 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 Principal Life. *Statement required by §164.508(c)(1)(iv).*

The following groups of persons employed or working for Principal Life may use my personal health information which is described above: employees of the underwriting, administration, claim or legal departments and any other personnel of Principal Life, 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 Principal Life. *Statement required by §164.508(c)(1)(ii).*

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Proposed Insured/Patient Copy – Sign Original

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).*

Information Form For Insurance Proposed Insured

Before consenting to testing, please read the following information:

To evaluate your insurability, the insurer named above (the Insurer) has requested that you provide a sample of your blood and/or oral fluids for testing and analysis. Tests which may be performed include determinations of blood cholesterol and related lipids (fats) and screening for liver or kidney disorders, diabetes, and immune disorders. One of the tests to be performed on this sample will be a test to determine the presence of human immunodeficiency virus (HIV) antibodies. By signing and dating this form you agree that this test may be done and that underwriting decisions will be based on the test result. The HIV Antibody Test consists of a series of three tests as outlined below which will be performed on your sample by a licensed laboratory through a medically accepted procedure.

AIDS:

Acquired Immunodeficiency Syndrome (AIDS) is a life-threatening disorder of the immune system, caused by a virus, HIV. The virus is transmitted by sexual contact with an infected person, from an infected mother to her newborn infant or by exposure to infected blood (as in needle sharing during IV drug use). Persons at high risk of contracting AIDS include males who have had sexual contact with another man, intravenous drug users, hemophiliacs, and sexual contacts with any of these persons. AIDS does not typically develop until a person has been infected with HIV for several years. A person may remain free of symptoms for years after becoming infected. If symptoms do develop, they may include fever (including night sweats), weight loss, swollen glands, fatigue, diarrhea or white spots in the mouth.

The HIV Antibody Test:

Purpose: This test is being run to determine whether you may have been infected with HIV. If you are infected, you are probably not insurable. This test is not a test for AIDS, AIDS can only be diagnosed by medical evaluation.

When an HIV Antibody test is performed, it will be performed only by a licensed laboratory and according to the following medical protocol:

- 1) An initial ELISA test will be done. If such test is negative, a negative finding will be reported by the laboratory to the Insurer.
- 2) If the initial ELISA test is positive, another ELISA test will be performed.
 - a) If the second ELISA test is also positive, a Western Blot test will be performed to confirm the positive results of the two ELISA tests.
 - b) If the second ELISA test is negative, a third ELISA test will be performed. If the third ELISA test is positive, a Western Blot test will be performed to confirm the previous positive results. If the third ELISA test is negative, a negative result will be reported to the Insurer.
- 3) Only if at least two ELISA tests and a Western Blot test are all positive will the result be reported as positive. All other results will be reported as negative by the laboratory to the Insurer.

This test is not a test for AIDS. It is a test for antibodies to the HIV virus, the causative agent for AIDS, and shows whether you have been exposed to the virus. A positive test result does not mean that you have AIDS but shows that the risk that you will develop problems with your immune system is significantly increased. If your test result is positive, you may wish to consider further independent testing at your own cost.

Confidentiality of Test Results:

All test results are required to be treated confidentially. They will be reported by the laboratory to the Insurer. The test results may be disclosed as required by law or may be disclosed to employees of the Insurer who have the responsibility to make underwriting decisions on behalf of the Insurer or to its outside legal counsel who need such information to effectively represent the Insurer in regard to your application. The results may be disclosed to a reinsurer, if the reinsurer is involved in the underwriting process. The test may be released to an insurance medical information exchange under procedures that are designed to assure confidentiality, including the use of general codes that also cover results of tests for other diseases or conditions not related to AIDS, or for the preparation of statistical reports that do not disclose the identity of any particular person.

Notification of Test Results:

If your test results are negative, no routine notification will be sent to you. If your test results are reported by the laboratory to the Insurer as being positive, you are entitled to that information if you so desire. Because a trained person should deliver that information to you so that you can understand clearly what the test result means, you are asked to list your private physician or other designee so that the Insurer can have him or her tell you the test result and explain its meaning.

Further Information:

For further information about AIDS, the meaning of HIV-related test results and the availability and location for HIV related counseling services, please call the Department of Health's state-wide toll-free number: 1-800-541-AIDS.

Consent:

I have read this Notice and Consent and I voluntarily consent to the withdrawal of blood from me, the testing of that blood, and the disclosure of the test results as described above.

 Name of physician for reporting a possible positive result

Address	City	State	ZIP
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There is also a form inside the blood profile kit which must be read and signed. If you choose not to sign below on this form or the form in the kit, we will be unable to consider your request for coverage. If you wish for us to continue processing, sign below.

X	X		
Signature of Proposed Insured or Parent/Guardian	Date MM/DD/YYYY		
Print Name			
Address	City	State	ZIP

Sign two copies. Send one signed copy to the Home Office. One copy is for the Insured.

Information Form For Insurance Proposed Insured

Before consenting to testing, please read the following information:

To evaluate your insurability, the insurer named above (the Insurer) has requested that you provide a sample of your blood and/or oral fluids for testing and analysis. Tests which may be performed include determinations of blood cholesterol and related lipids (fats) and screening for liver or kidney disorders, diabetes, and immune disorders. One of the tests to be performed on this sample will be a test to determine the presence of human immunodeficiency virus (HIV) antibodies. By signing and dating this form you agree that this test may be done and that underwriting decisions will be based on the test result. The HIV Antibody Test consists of a series of three tests as outlined below which will be performed on your sample by a licensed laboratory through a medically accepted procedure.

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 - b) If the second ELISA test is negative, a third ELISA test will be performed. If the third ELISA test is positive, a Western Blot test will be performed to confirm the previous positive results. If the third ELISA test is negative, a negative result will be reported to the Insurer.
- 3) Only if at least two ELISA tests and a Western Blot test are all positive will the result be reported as positive. All other results will be reported as negative by the laboratory to the Insurer.

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Confidentiality of Test Results:

All test results are required to be treated confidentially. They will be reported by the laboratory to the Insurer. The test results may be disclosed as required by law or may be disclosed to employees of the Insurer who have the responsibility to make underwriting decisions on behalf of the Insurer or to its outside legal counsel who need such information to effectively represent the Insurer in regard to your application. The results may be disclosed to a reinsurer, if the reinsurer is involved in the underwriting process. The test may be released to an insurance medical information exchange under procedures that are designed to assure confidentiality, including the use of general codes that also cover results of tests for other diseases or conditions not related to AIDS, or for the preparation of statistical reports that do not disclose the identity of any particular person.

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Address _____ City _____ State _____ ZIP _____

There is also a form inside the blood profile kit which must be read and signed. If you choose not to sign below on this form or the form in the kit, we will be unable to consider your request for coverage. If you wish for us to continue processing, sign below.

X _____ **X** _____
Signature of Proposed Insured or Parent/Guardian Date MM/DD/YYYY

Print Name
Address _____ City _____ State _____ ZIP _____

Sign two copies. Send one signed copy to the Home Office. One copy is for the Insured.