Statement of Health - AR

Principal Life Insurance Company
Des Moines, IA 50392-0002

Principal®

PLEASE USE BLACK INK

PLEASE ENTER DATES AS MM/DD/YYYY

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.
3. When coverage is being requested for an eligible dependent(s), 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 if spouse or domestic partner coverage is being requested.
4. After completing and signing this form, make a copy for your records.

Employee Information

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

Mailing address (street)

City	State	ZIP code

Email address

Home phone number	Employer name

Eligible Dependent Information – Please provide the requested information for the eligible dependents electing coverage.

Name (last, first, middle initial) Spouse or domestic partner	Gender	Social security number	Date of birth
	☐ 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. 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 or taking prescription medication?

3. ☐ yes ☐ no — Is any person currently pregnant?

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

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

   ☐ cancer/tumor(s) ☐ liver disorder/hepatitis ☐ bone/joint disorder ☐ infertility

   ☐ back/spine disorder ☐ kidney/urinary disorder ☐ digestive disorder ☐ blood disorder

   ☐ stroke ☐ migraines/headaches ☐ alcohol/drug abuse ☐ gland/thyroid disorder

   ☐ skin/eyes/ears/nose/throat disorder ☐ multiple sclerosis/neurological disorder ☐ organ or other transplants

   ☐ asthma/respiratory disorder ☐ heart or circulatory disorder ☐ psychological/mental disorder

   ☐ Other conditions – including prescription medicine _____

   _____

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

   ☐ Diabetes – last HbA1c reading and date _____ / _____

6. ☐ yes ☐ no — **In the last 5 years,** has any person had, been treated for or been diagnosed as having HIV (Human Immunodeficiency Virus) infection, positive HIV test or AIDS (Acquired Immune Deficiency Syndrome), or ARC (AIDS Related Complex)?

Provide details for all "yes" answers on Page 3.

Name of person diagnosed | Date diagnosed | Date released from medical care

Diagnosis of illness or condition

If not released, describe current symptoms or problems

Type of treatment (for example surgery or therapy) and names of all current prescription medications including dosage

Frequency of treatment

☐ weekly ☐ monthly ☐ yearly ☐ other

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

Name of person diagnosed | Date diagnosed | Date released from medical care

Diagnosis of illness or condition

If not released, describe current symptoms or problems

Type of treatment (for example surgery or therapy) and names of all current prescription medications including dosage

Frequency of treatment

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If more space is needed, attach a separate page giving full details. Sign and date all those pages.

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, (d) pharmacy benefit managers, and (e) 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. No information will be considered to have been given to Principal Life unless it is stated on this form.
- 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.
- Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
- 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, pharmacy benefit manager, 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 signed. 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 additional medical records may be requested at the time a claim is filed.
- 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.
- Health information obtained will not be re-disclosed without my authorization unless permitted by law, in which case it may not be protected under federal privacy rules.

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

*Spouse's or domestic partner's signature only required if Voluntary Term Life or Critical Illness coverage is elected.