Principal Financial Group

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

Principal Life Insurance Company

Statement of Health - MT

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	Social security number	Date of birth
	male female		

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.

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 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 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	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 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)? |

If applying for Critical Illness, complete question 7.

| 7. | yes | no | 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. 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

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

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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

- 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.

- Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement, may be guilty of insurance fraud.

- 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 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 coverage. This information will not be used for any purposes prohibited by law.

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