

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 state registered domestic partner or nonregistered domestic partner must sign the last page of this form if spouse or state registered domestic partner or nonregistered domestic partner coverage is being requested.
4. After completing and signing this form, make a copy for your records.

Why is this Evidence of Insurability being submitted?

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

If you are applying for critical illness coverage, do you or your eligible dependents have other benefits from an individual or group policy or contract that arranges for or provides medical, hospital, and surgical coverage not designed to supplement other private or governmental plans in force as of the date of this application for critical illness coverage?

NOTE: Critical Illness coverage cannot be issued to a person who does not have such insurance in force.

employee:    yes      no    spouse or state registered domestic partner or nonregistered domestic partner:    yes      no

**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 male      female	Social security number	Date of birth

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 state registered domestic partner's or nonregistered domestic partner's height \_\_\_ ft. \_\_\_\_\_ in. weight \_\_\_\_\_ lbs.

2.    yes    no    To the best of your knowledge, is any person currently pregnant?

3.    yes    no    **In the past 5 years**, to the best of your knowledge, has any person had surgery, been hospitalized or been diagnosed with or treated for a medical condition by a medical professional? Provide results of all tests.

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

cancer	infertility	stroke	hepatitis
tumor(s)	alcohol/drug use	cirrhosis	nephritis
irritable bowel	colitis/Crohn's disease	ulcer	psychological/
organ or other	multiple sclerosis/	anemia	mental condition
transplants	neurological disease		

High blood pressure – last reading and date \_\_\_\_\_ / \_\_\_\_\_  
 Diabetes – last HbA1c reading and date \_\_\_\_\_ / \_\_\_\_\_

5.    yes    no    **In the past 5 years**, to the best of your knowledge, has any person been diagnosed with or treated for or had a study for which medical results are pending for any chronic or progressive disease of any of the following (check all that apply)?

liver	kidney/urinary tract	muscles/bones/joints	pancreas
gallbladder	thyroid	reproductive system	lungs/respiratory
heart or circulatory	digestive system	skin/eyes/ear/nose/	system
system		throat	

6.    yes    no    **In the past 12 months**, to the best of your knowledge, has any person taken or are they currently taking any prescription medication?

7.    yes    no    **In the last 5 years**, to the best of your knowledge, has any person had, been treated for or been diagnosed as having AIDS (Acquired Immune Deficiency Syndrome) or ARC (Aids Related Complex)?

**California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.**

If applying for Critical Illness, complete question 8.

8.    yes    no    To the best of your knowledge, have any of your natural parents, brothers or sisters been diagnosed with coronary artery disease, stroke, diabetes or cancer prior to age 55?  
 Employee – if yes, disease and age at diagnosis: \_\_\_\_\_  
 Spouse or state registered domestic partner or nonregistered 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		

**Health Information (continued)****120**

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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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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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		

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 Evidence of Insurability. In addition, we may contact the following persons/entities besides yourself for personal data about any proposed insured, including (a) spouse or state registered domestic partner or nonregistered domestic partner, (b) employer, (c) medical professionals or institutions, and (d) government agencies. 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 request a copy of any employment or medical information (including physical, mental, drug, or alcohol use history) about you or your dependents contained in Principal Life files (medical information may be disclosed only to you, your dependent, or a medical professional).
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 employment or medical information in our records, including physical, mental, drug or alcohol use history;
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 contested.
- Any false statement made on this form will not bar the right to recovery under the group policy(ies) unless such false statement was made with actual intent to deceive or unless it materially affected either the acceptance of the risk or the hazard assumed by Principal Life.
- 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 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. 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.

<b>Employee's signature</b> <b>X</b>	<b>Date signed</b>
<b>Spouse's or state registered domestic partner's or nonregistered domestic partner's signature</b> <b>X</b>	<b>Date signed</b>

# Authorization for Release of Personal Health Information – All States

(Applicable to Group Life and Disability Insurance Customers)

Principal Life Insurance Company  
P.O. Box 4934  
Grand Island, NE 68802



**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 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 the Company. 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 the Company 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 the Company. *Statement required by §164.508(c)(1)(iv).*

The following groups of persons employed or working for the Company may use my personal health information which is described above: employees of the underwriting, administration, claim or legal departments and any other personnel of the Company, 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 the Company. *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: Group Medical Underwriting, Principal Life Insurance Company, 711 High Street, Des Moines, IA 50392-2070. I understand that a revocation is not effective if the Company 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, the Company 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.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I further understand that My Providers cannot condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this authorization.

Signature of Proposed Insured/Patient or Personal Representative

Date

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