Principal Life Insurance Company

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

Evidence of Insurability - CA

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	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. 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/ mental condition
   ☐ organ or other transplants ☐ multiple sclerosis/ neurological disease ☐ anemia

   ☐ 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 system
   ☐ heart or circulatory system ☐ digestive system ☐ skin/eyes/ear/nose/ 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

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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 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.

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