

SERFF Tracking Number: PRLD-125840447 State: Arkansas
Filing Company: Principal National Life Insurance Company State Tracking Number: 40642
Company Tracking Number: AA1800N-L-PNL
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
Product Name: 2009 Apps/Life
Project Name/Number: 2009 Apps/Life/AA1800N

Filing at a Glance

Company: Principal National Life Insurance Company

Product Name: 2009 Apps/Life SERFF Tr Num: PRLD-125840447 State: ArkansasLH
TOI: L08 Life - Other SERFF Status: Closed State Tr Num: 40642
Sub-TOI: L08.000 Life - Other Co Tr Num: AA1800N-L-PNL State Status: Approved-Closed
Filing Type: Form Co Status: Reviewer(s): Linda Bird
Author: R Grubb Disposition Date: 10/24/2008
Date Submitted: 10/22/2008 Disposition Status: Approved
Implementation Date Requested: 03/17/2009 Implementation Date:

State Filing Description:

General Information

Project Name: 2009 Apps/Life Status of Filing in Domicile: Authorized
Project Number: AA1800N Date Approved in Domicile: 09/23/2008
Requested Filing Mode: Review & Approval Domicile Status Comments: Approved by our
domicile state, Iowa, on 9-23-2008.
Explanation for Combination/Other: Market Type: Individual
Submission Type: New Submission Group Market Size:
Overall Rate Impact: Group Market Type:
Filing Status Changed: 10/24/2008
State Status Changed: 10/24/2008 Deemer Date:
Corresponding Filing Tracking Number: PRLD-125840446
Filing Description:
RE New Submission - Individual Life Applications
Form AA 1800N, et al

We have reviewed our procedures and assure you that we are in compliance with and provide the notice required by Arkansas Code Ann. 23-79-138.

We have reviewed our issue procedures and assure you that we are in compliance with and provide the Life and Health

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guaranty notice required by Regulation 49.

We certify that the forms in the above numbered submission meet the provision of Rule and Regulation 19 regarding unfair sex discrimination in the sale of insurance, as well as all applicable requirements of the Department.

Enclosed for your approval are the application forms listed on the accompanying list. These forms are new forms not replacing any previously approved forms for Principal National Life Insurance Company.

The previous version of these forms were previously filed and approved by your department for use by Principal Life Insurance Company. The forms have been revised in order that they may be used by both Principal Life Insurance Company and Principal National Life Insurance Company, a sister company to Principal Life Insurance Company.

Please note that these application forms are concurrently being submitted to your Department for use by Principal Life Insurance Company in PRLD-125840446. We would appreciate any efforts you can make to coordinate the review of these forms.

The forms enclosed for your review and approval are in final printed form, subject only to minor modification in format, paper size, stock, ink, border, company logo, and adaptation to computer printing. In addition, depending on printer capabilities, the forms may be printed either simplex or duplex.

If you have questions or would like more information, please contact me using any of the options listed in the Companies and Contact tab.

Company and Contact

Filing Contact Information

Rosemary Grubb, Senior Analyst grubb.rosemary@prinipal.com
711 High Street (800) 255-6603 [Phone]
Des Moines, IA 50392-0001 (515) 235-5494[FAX]

Filing Company Information

Principal National Life Insurance Company CoCode: 71161 State of Domicile: Iowa
711 High Street Group Code: 332 Company Type: Life, Health &

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Annuities

Des Moines, IA 50392-0001
(515) 246-7062 ext. [Phone]

Group Name:
FEIN Number: 34-1022982

State ID Number:

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Filing Fees

Fee Required? Yes
Fee Amount: \$400.00
Retaliatory? No
Fee Explanation: 20 forms @ \$20 each = \$400.00
Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Principal National Life Insurance Company	\$400.00	10/22/2008	23393403

SERFF Tracking Number:	PRLD-125840447	State:	Arkansas
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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved	Linda Bird	10/24/2008	10/24/2008

Amendments

Item	Schedule	Created By	Created On	Date Submitted
List of submitted forms	Supporting Document	R Grubb	10/22/2008	10/22/2008

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Disposition

Disposition Date: 10/24/2008

Implementation Date:

Status: Approved

Comment:

Rate data does NOT apply to filing.

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Item Type	Item Name	Item Status	Public Access
Supporting Document	Certification/Notice		Yes
Supporting Document	Application		No
Supporting Document	List of submitted forms		Yes
Form	Insurance Application		Yes
Form	Life Insurance Application		Yes
Form	Life Insurance Application		Yes
Form	Life Insurance Conversion/Purchase Option/Policy Split Application		Yes
Form	Life Insurance Adjustment Application		Yes
Form	Application for Multi-Life Guaranteed Issue Life Insurance		Yes
Form	Adjustment Application for Multi-Life Life Insurance Policy(s)		Yes
Form	Life Insurance Conditional Receipt		Yes
Form	Life Insurance 1035 Conditional Receipt		Yes
Form	Supplemental Statement		Yes
Form	Life Insurance Adjustment Conditional Receipt		Yes
Form	Worksite Term Life Insurance Application		Yes
Form	Application Supplement		Yes
Form	Application Supplement - Life Insurance		Yes
Form	Guaranteed/Simplified Issue Life Insurance Application		Yes
Form	Medical Questionnaire		Yes
Form	Amendment to Application		Yes
Form	Amendment and Acceptance Form		Yes
Form	Application for Reinstatement Of Policy		Yes
Form	Financial Underwriting Supplement		Yes

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Amendment Letter

Amendment Date:

Submitted Date: 10/22/2008

Comments:

I neglected to attach the list referenced in the submission information to the supporting document schedule. The list is now attached. Please accept my apology for this oversight.

Changed Items:

Supporting Document Schedule Item Changes:

User Added -Name: List of submitted forms

Comment: Attached is a list of submitted forms.

AR-Application forms being filed.pdf

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Form Schedule

Lead Form Number: AA 1800 N

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	AA 1800 N	Application/ Enrollment Form	Insurance Application	Initial		59	AA1800N.pdf
	AA 1900N AR	Application/ Enrollment Form	Life Insurance Application	Initial		51	AA1900NAR.pdf
	AA 2000 N	Application/ Enrollment Form	Life Insurance Application	Initial		46	AA2000N.pdf
	AA 3328 N	Application/ Enrollment Form	Life Insurance Conversion/Purchase Option/Policy Split Application	Initial		51	AA3328N.pdf
	AA 3329 N	Application/ Enrollment Form	Life Insurance Adjustment Application	Initial		45	AA3329N.pdf
	AA 3406 N	Application/ Enrollment Form	Application for Multi-Life Guaranteed Issue Life Insurance	Initial		50	AA3406N.pdf
	AA 3407 N	Application/ Enrollment Form	Adjustment Application for Multi-Life Life Insurance Policy(s)	Initial		50	AA3407N.pdf
	AA 3432 N	Application/ Enrollment Form	Life Insurance Conditional Receipt	Initial		50	AA3432N.pdf
	AA 3433 N	Application/ Enrollment Form	Life Insurance 1035 Conditional Receipt	Initial		55	AA3433N.pdf
	AA 3443 N AR	Application/ Enrollment Form	Supplemental Statement	Initial		55	AA3443NAR.pdf

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AA 3447 N	Application/ Life Insurance Enrollment Adjustment Form Conditional Receipt	Initial	50	AA3447N.pdf
AA 3450 N	Application/Worksite Term Life Enrollment Insurance Application Form	Initial	47	AA3450N.pdf
AA 372 N	Application/ Application Enrollment Supplement Form	Initial	71	AA372N.pdf
AA 631 N	Application/ Application Enrollment Supplement - Life Form Insurance	Initial	52	AA631N.pdf
AA 648 N	Application/ Guaranteed/Simplified Enrollment Issue Life Form Insurance Application	Initial	45	AA648N.pdf
AA 672 N	Application/ Medical Enrollment Questionnaire Form	Initial	61	AA672N.pdf
AA 973 N	Application/ Amendment to Enrollment Application Form	Initial	52	AA973N.pdf
AA 974 N	Application/ Amendment and Enrollment Acceptance Form Form	Initial	50	AA974N.pdf
AA 836 N AR	Application/ Application for Enrollment Reinstatement Of Form Policy	Initial	50	AA836NAR.pdf
AA 3448 N	Application/ Financial Enrollment Underwriting Form Supplement	Initial	48	AA3448N.pdf



Principal Life Insurance Company
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P.O. Box 10431
 Des Moines, IA 50306-0431

**Insurance
 Application**

Only one company is the issuer and responsible for obligations of any given policy and is hereinafter referred to as "the Company".

Proposed Insured _____
 D.O.B. ____ / ____ / _____ Policy Number (If known) _____

PART B – (Continued)

INCOME/OCCUPATION

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

7. Annual income from occupation \$ _____ Other Income \$ _____
 Source of other income _____ Net Worth (Assets – Liabilities) \$ _____

8. Primary occupation _____ Employer _____

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 workers' 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

Quest. #	Include dates and details as requested above.



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Proposed Insured _____
 D.O.B. ____ / ____ / _____ Policy Number (If known) _____

PART B – (Continued)

MEDICAL HISTORY (Provide details to yes answers, questions 21-26 below)

21. Who is your Primary Physician? None
- | | |
|---------|--------------|
| a. Name | Phone Number |
| Street | City |
| | State |
| | Zip |
- b. Date last seen, reason and details

22. In the last ten years:
- a. have you had any medical tests, hospitalization, illness or injury not provided in response to a previous question? (If yes, explain below) Yes No
- b. have you consulted a doctor, chiropractor, psychiatrist, psychologist, counselor, therapist or other healthcare provider not provided in response to a previous question? (If yes, explain below) Yes No
23. Are you taking or have you been advised to take any medication or treatment not provided in response to a previous question? (If yes, explain below) Yes No
24. Current Ht. _____ Wt. _____ Have you lost more than 10 lbs. in the last year? Yes No
 If yes, _____ lbs./kgs. Indicate reason _____
25. a. Has either of your natural parents lived to at least age 60? Yes No
 b. Do any of your natural parents or siblings have a history of diabetes, cancer, stroke or heart disease? Yes No
 If yes, provide details (i.e., relationship, type of disease, age diagnosed, current age or age at death):

26. Have you ever had any life, health or disability insurance rated, ridered or declined? (If yes, explain below) Yes No

DETAILS TO QUESTIONS 21-26

Quest. #	Include dates and details as requested above.



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**Life Insurance
 Application**

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Proposed Insured _____ D.O.B. ___ / ___ / _____

PART D – AGREEMENT/ACKNOWLEDGMENT OF DELIVERY

AGREEMENT: Statements In Application: I have read all the questions and answers obtained during the application process, including Part B on the primary Proposed Insured. I represent all statements are true and complete to the best of my knowledge and belief and were correctly recorded before I signed my name below. I have also signed a copy of this Agreement/Acknowledgment of Delivery included with my policy. I understand and agree the statements in the application, including all of its parts and statements by the Proposed Insured in any medical questionnaire or supplement, will be the basis for and form a part of the policy. I understand that misrepresentations could mean denial of an otherwise valid claim and rescission of the policy during the contestable period.

When Policy Coverage Becomes Effective: I understand and agree that if a policy is issued as applied for with a premium deposit paid, policy coverage will become effective as of issuance. The Company agrees to pay any proceeds pursuant to policy terms subject to the acceptance of the proposed owner and signing of Part D, if applicable. I understand and agree that if a policy is issued as other than applied for or without a premium deposit (C.O.D.), then policy coverage is not effective and the Company shall incur no policy liability unless:

- 1) A policy issued on this application has been physically delivered to and accepted by the owner and the first premium paid; and
- 2) At the time of such delivery and payment, the person to be insured is actually in the state of health and insurability represented in the application, medical questionnaire, or amendment that becomes a part of this application; and
- 3) This form is signed by me and the Proposed Insured (if different than me) and dated at delivery.

If these conditions are met, the policy is deemed effective on the Policy Date stated in the policy data pages.

When an Adjustment Becomes Effective: I understand and agree that if I apply to adjust my policy coverage, any adjustment approved by the Company is effective as of the Adjustment Date shown on the new data pages for the policy, provided that I and the proposed insured (if different than me) sign this form and any amendment form, if applicable, and return such forms to the Company within 30 days of the adjustment delivery date.

Limitation of Authority: I understand and agree no agent, broker, licensed 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 the 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 agent, broker, licensed representative, telephone interviewer, medical examiner or other person shall be considered knowledge of the Company unless such fact is stated in the application.

ACKNOWLEDGMENT OF DELIVERY:

I acknowledge policy numbered _____ was delivered to me today and is based on the life of _____.

INSURABILITY DATES:

If a premium deposit was submitted with Part A and C of the application, I verify that all information in Part B of the application is true and complete and is correctly recorded as of _____.

If the application was submitted without a premium deposit (C.O.D.), I verify that all information in the Part A and B of the application including all parts and statements by the Proposed Insured in any medical questionnaire or supplement accurately reflects the Proposed Insured's health and insurability as of the date I sign this form.

Warning: It is a crime to provide false, misleading, or incomplete information to an insurance company for the purpose of defrauding the company or any other person. Penalties include imprisonment and/or fines and denial of insurance benefits.

SIGNATURES

Signature of Proposed Insured (If age 15 or over) X	Signature of Parent (If Proposed Insured is under age 18 and Parent has not signed as Owner) X
Signature of Owner(s) (If other than Proposed Insured). If corporation, an officer other than the Proposed Insured must sign, include officer's title. If joint ownership or Trust, all joint owners/trustees must sign, include 'Trustee' after signature.	
X	Title
X	Title
X	Title
Date	



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**Life Insurance
 Application**

Only one company is the issuer and responsible for obligations of any given policy and is hereinafter referred to as "the Company".

PART A

1. PERSONAL INFORMATION ABOUT THE PROPOSED INSURED

Name (First, Middle, Last)	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth / /
Primary Residence Street Address	Social Security Number - -	Birthplace (State, or Country if not U.S.)
City, State, Zip Code	Driver's License Number	State Issued
Home Phone Number ()	Occupation	
Work Phone Number ()	Workplace Zip Code	

2. BASIC COVERAGE APPLIED FOR

Product _____	Policy Planned Premium \$ _____
Face Amount (excluding riders) \$ _____	Premium Frequency: (choose one) <input type="checkbox"/> Annual <input type="checkbox"/> Semi Annual <input type="checkbox"/> Quarterly <input type="checkbox"/> Single Pay
Death Benefit Option if applicable: <input type="checkbox"/> Option 1: Level Face Amount <input type="checkbox"/> Option 2: Face + Accumulated/Policy Value <input type="checkbox"/> Option 3: Face + Premiums Paid Less Partial Surrenders	<input type="checkbox"/> EFT (complete EFT form + attach sample check) List Bill Number _____ <input type="checkbox"/> Annual <input type="checkbox"/> Semi Annual <input type="checkbox"/> Quarterly <input type="checkbox"/> Monthly Unscheduled Premium \$ _____

3. BENEFITS/RIDERS (Some riders are not available with all products)

<input type="checkbox"/> Accidental Death – Amount \$ _____	<input type="checkbox"/> Policy Split Option
<input type="checkbox"/> Accounting Benefit	<input type="checkbox"/> Salary Increase – Amount \$ _____
<input type="checkbox"/> Alternate Cash Surrender Value	<input type="checkbox"/> Single Life Term – Amount \$ _____
<input type="checkbox"/> Change of Insured	<input type="checkbox"/> Waiver of Premium/Specified Premium
<input type="checkbox"/> Children Term – Amount \$ _____	<input type="checkbox"/> Waiver of Monthly Deductions/Monthly Policy Charges
<input type="checkbox"/> Four Year Term	<input type="checkbox"/> _____
<input type="checkbox"/> 20 Year Premium Guarantee	<input type="checkbox"/> _____

4. BENEFICIARY INFORMATION

Primary Beneficiary	Relationship to Proposed Insured
Contingent Beneficiary	Relationship to Proposed Insured
Single Life Term Rider Beneficiary	Relationship to Proposed Insured

Proposed Insured Name _____

5. OWNERSHIP INFORMATION (Complete if different than the Insured)

Owner Name (If trust, provide name of trust*)	Relationship to Proposed Insured
Primary Residence Street Address	Taxpayer Identification Number
City, State, Zip Code	Date of Birth (If trust, provide date of trust*)
Joint Owner Name	Relationship to Proposed Insured
Primary Residence Street Address	Taxpayer Identification Number
City, State, Zip Code	Date of Birth
Contingent Owner Name	Relationship to Proposed Insured

* Submit copy of trust with this application.

6. CHANGE OF OWNERSHIP

- (a) Is there an intention that any group of investors will obtain any right, title, or interest in any policy issued on the life of the Proposed Insured(s) as a result of this application?..... Yes No
If yes, explain. _____
- (b) Will you borrow money to pay the premiums for this policy or have someone else pay these premiums for you in return for an assignment of policy values back to them? Yes No
If yes, explain and complete premium financing acknowledgment form. _____

7. OTHER INSURANCE

- (a) Is there other life insurance or annuities in force or applied for? Yes No
(If yes, list all other life insurance or annuities in force or currently being applied for, even if sold, assigned, or viaticated.)

Insured's Name	Company	Amount	Policy Number	Check if Pending	Year Issued	Primary Purpose
		\$		<input type="checkbox"/>		
		\$		<input type="checkbox"/>		
		\$		<input type="checkbox"/>		
		\$		<input type="checkbox"/>		

- (b) If coverage is pending, will all pending coverage be accepted? Yes No
If no, explain. _____
- (c) Have you transferred or assigned any right, title, or interest in any life insurance or annuity contract other than absolute assignment for Internal Revenue Code 1035 exchange? Yes No
If yes, explain. _____

8. REPLACEMENT

- (a) Will the insurance applied for with this application replace or affect any of the owner's other life or annuity contracts (including pending coverage provided with a binding receipt)? Yes No
If yes, list company name(s) and policy number(s) and provide necessary forms:

- (b) Is this an Internal Revenue Code section 1035 exchange? Yes No



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PART C – AGREEMENT/AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

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 the application, including statements by the Proposed Insured in any medical questionnaire that becomes a part of this application, shall be the basis of any insurance issued. I also understand that misrepresentations can mean denial of an otherwise valid claim and rescission of the policy during the contestable period.

I understand that the policy(ies) delivered to me may be from a different issuer than what was listed in the application. I understand and agree that my acceptance of the policy(ies) shall be considered an amendment to this application. Each policy has only one issuing company and that issuer is solely responsible for the obligations under that policy.

When Policy Coverage Becomes Effective: I understand and agree that if a policy is issued as applied for with a premium deposit paid, policy coverage will become effective as of issuance. The Company agrees to pay any proceeds pursuant to policy terms subject to the acceptance of the proposed owner and signing of Part D, if applicable.

I understand and agree that if a policy is issued as other than applied for or without a premium deposit (C.O.D.), then policy coverage is not effective and the Company shall incur no policy liability unless:

- 1) A policy issued on this application has been physically delivered to and accepted by the owner and the first premium paid; and
- 2) At the time of such delivery 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 or the Acknowledgment of Delivery form is signed by me and the Proposed Insured (if different than me) and dated at delivery.

If these conditions are met, the policy is deemed effective on the Policy Date stated in the policy data pages.

Limitation of Authority: I understand and agree that no agent, broker, licensed 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 agent, broker, licensed representative, telephone interviewer, medical examiner or other person shall be considered knowledge of the Company unless such fact is stated in the application.

If my employer is the owner and beneficiary on this application: I agree to allow my employer to purchase insurance on my life. I understand that my employer or trustee will have all present and future rights of ownership and will also be the beneficiary of the policy. There is no obligation, on my part, to pay the policy premiums. I acknowledge that as an employee, the employer or trustee has an insurable interest in my life. I understand and agree that my administrators, estate, heirs and assignees have no rights to the policy or any policy proceeds. I understand that the maximum face amount for which I could be insured at the time of issuance is generally not more than 30 times compensation, up to a maximum of \$30,000,000, subject to underwriting guidelines. I further authorize my employer or trustee to increase or decrease the amount of insurance on my life in the future without another consent from me and without further notice to me as long as I am employed by the employer. I consent to and authorize my employer, trustees, or its successors to continue to be the owner and beneficiary of this policy(ies) indefinitely including after the end of my employment by the employer.

AUTHORIZATION

I authorize any insurance (or reinsuring) company, consumer reporting agency, governmental agency, insurance agent, broker, licensed representative, or any other organization, institution or person having personal information (including physical, mental, drug or alcohol use history) regarding me, the named proposed insured, to provide to the Company, its representatives or reinsurers, any such data. I authorize the Company or its representative to conduct a telephone interview in connection with my application for insurance.

I understand and agree to sign any authorization that is required to authorize any doctor, hospital, clinic, health care provider, laboratory, pharmacy benefit manager or any other institution having personal information (including physical, mental, drug or alcohol use history) regarding the named proposed insured to provide the Company, its representatives or reinsurers any such data. I understand that if I refuse to sign an authorization to release my complete medical record, the Company may not be able to process my application for life insurance coverage.

PART C – AGREEMENT/AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION (CONTINUED)

I authorize the Medical Information Bureau (MIB, Inc.) to furnish the above data to the Company, its representative or its reinsurers. I authorize the Company or its representative 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 agree that this authorization shall be valid for 24 months from the date of this application. 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 a photocopy of this authorization is as valid as the original. I have received a copy of this authorization. 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.

C.O.D. or Advance Premium Paid:

- This application is C.O.D. and I have not been given any Conditional Receipt with this application.
- I have paid \$ _____ as an advance premium with this application which is no less than one month's advance premium and I have been given the Life Insurance Conditional Receipt. In return I have read, understand, and agree to its terms.
- I have submitted an Absolute Assignment form with this application and I have been given the Life Insurance 1035 Conditional Receipt. In return I have read, understand, and agree to its terms.

Warning: It is a crime to provide false, misleading, or incomplete information to an insurance company for the purpose of defrauding the company or any other person. Penalties include imprisonment and/or fines and denial of insurance benefits.

OWNER TAXPAYER IDENTIFICATION NUMBER CERTIFICATION: As proposed owner of this contract, I certify under penalties of perjury: (1) The taxpayer identification number shown on this application is correct, (2) I am not subject to IRS backup withholding, and (3) I am a U.S. person (which includes a U.S. resident alien). If subject to backup withholding complete W-9. If not a U.S. person complete W-8. **The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.**

Signatures – Please read all of the above Agreements, Authorizations, and Certification before signing below.

Signature of Proposed Insured (If age 15 or over)				
X				
Signature of Parent (If Proposed Insured is under age 18 and Parent has not signed as Owner)				
X				
Signature of Owner(s), if other than Proposed Insured. If corporation, an officer other than the Proposed Insured must sign and include officer's title. If joint ownership or Trust, all joint owners/trustees must sign. If signing as a Trustee include 'Trustee' as title.				
				Title
X				
				Title
X				
Signed at: City	State	Date	Signature of Licensed Agent/Broker/Representative	License Number
			X	
Cosignature by resident Licensed Agent/Broker/Representative, if applicable in your state			Date	License Number
X				



Principal Life Insurance Company
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Members of Principal Financial Group®

P.O. Box 10431
Des Moines, IA 50306-0431

Life Insurance
Application

Only one company is the issuer and responsible for obligations of any given policy and is hereinafter referred to as "the Company".

PART C – AGREEMENT/AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

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 the application, including statements by the Proposed Insured in any medical questionnaire that becomes a part of this application, shall be the basis of any insurance issued. I also understand that misrepresentations can mean denial of an otherwise valid claim and rescission of the policy during the contestable period.

I understand that the policy(ies) delivered to me may be from a different issuer than what was listed in the application. I understand and agree that my acceptance of the policy(ies) shall be considered an amendment to this application. Each policy has only one issuing company and that issuer is solely responsible for the obligations under that policy.

When Policy Coverage Becomes Effective: I understand and agree that if a policy is issued as applied for with a premium deposit paid, policy coverage will become effective as of issuance. The Company agrees to pay any proceeds pursuant to policy terms subject to the acceptance of the proposed owner and signing of Part D, if applicable.

I understand and agree that if a policy is issued as other than applied for or without a premium deposit (C.O.D.), then policy coverage is not effective and the Company shall incur no policy liability unless:

- 1) A policy issued on this application has been physically delivered to and accepted by the owner and the first premium paid; and
- 2) At the time of such delivery 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 or the Acknowledgment of Delivery form is signed by me and the Proposed Insured (if different than me) and dated at delivery.

If these conditions are met, the policy is deemed effective on the Policy Date stated in the policy data pages.

Limitation of Authority: I understand and agree that no agent, broker, licensed 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 agent, broker, licensed representative, telephone interviewer, medical examiner or other person shall be considered knowledge of the Company unless such fact is stated in the application.

If my employer is the owner and beneficiary on this application: I agree to allow my employer to purchase insurance on my life. I understand that my employer or trustee will have all present and future rights of ownership and will also be the beneficiary of the policy. There is no obligation, on my part, to pay the policy premiums. I acknowledge that as an employee, the employer or trustee has an insurable interest in my life. I understand and agree that my administrators, estate, heirs and assignees have no rights to the policy or any policy proceeds. I understand that the maximum face amount for which I could be insured at the time of issuance is generally not more than 30 times compensation, up to a maximum of \$30,000,000, subject to underwriting guidelines. I further authorize my employer or trustee to increase or decrease the amount of insurance on my life in the future without another consent from me and without further notice to me as long as I am employed by the employer. I consent to and authorize my employer, trustees, or its successors to continue to be the owner and beneficiary of this policy(ies) indefinitely including after the end of my employment by the employer.

AUTHORIZATION

I authorize any insurance (or reinsuring) company, consumer reporting agency, governmental agency, insurance agent, broker, licensed representative, or any other organization, institution or person having personal information (including physical, mental, drug or alcohol use history) regarding me, the named proposed insured, to provide to the Company, its representatives or reinsurers, any such data. I authorize the Company or its representative to conduct a telephone interview in connection with my application for insurance.

I understand and agree to sign any authorization that is required to authorize any doctor, hospital, clinic, health care provider, laboratory, pharmacy benefit manager or any other institution having personal information (including physical, mental, drug or alcohol use history) regarding the named proposed insured to provide the Company, its representatives or reinsurers any such data. I understand that if I refuse to sign an authorization to release my complete medical record, the Company may not be able to process my application for life insurance coverage.

CLIENT COPY

PART C – AGREEMENT/AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION (CONTINUED)

I authorize the Medical Information Bureau (MIB, Inc.) to furnish the above data to the Company, its representative or its reinsurers. I authorize the Company or its representative 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 agree that this authorization shall be valid for 24 months from the date of this application. 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 a photocopy of this authorization is as valid as the original. I have received a copy of this authorization. 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.

C.O.D. or Advance Premium Paid:

- This application is C.O.D. and I have not been given any Conditional Receipt with this application.
- I have paid \$ _____ as an advance premium with this application which is no less than one month's advance premium and I have been given the Life Insurance Conditional Receipt. In return I have read, understand, and agree to its terms.
- I have submitted an Absolute Assignment form with this application and I have been given the Life Insurance 1035 Conditional Receipt. In return I have read, understand, and agree to its terms.

Warning: It is a crime to provide false, misleading, or incomplete information to an insurance company for the purpose of defrauding the company or any other person. Penalties include imprisonment and/or fines and denial of insurance benefits.

OWNER TAXPAYER IDENTIFICATION NUMBER CERTIFICATION: As proposed owner of this contract, I certify under penalties of perjury: (1) The taxpayer identification number shown on this application is correct, (2) I am not subject to IRS backup withholding, and (3) I am a U.S. person (which includes a U.S. resident alien). If subject to backup withholding complete W-9. If not a U.S. person complete W-8. **The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.**

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Principal Life Insurance Company
 Principal National Life Insurance Company
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P.O. Box 10431
 Des Moines, IA 50306-0431

**Life Insurance
 Conversion/
 Purchase
 Option/Policy
 Split Application**

Only one company is the issuer and responsible for obligations of any given policy and is hereinafter referred to as "the Company".

1. PERSONAL INFORMATION ABOUT THE PROPOSED INSURED

Name (First, Middle, Last)	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth / /
Primary Resident Street Address	Social Security Number - -	Birthplace (State, or Country if not U.S.)
City, State, Zip Code	Workplace Zip Code	
Home Phone Number ()	Work Phone Number ()	

2. CONVERSION/PURCHASE OPTION/POLICY SPLIT INFORMATION

Convert from: Policy _____
 Rider _____ EPO _____ Spouse Term _____ Family/Child Term _____

Convert full guaranteed amount
 Convert \$ _____ with remaining amount: Continued Canceled
 Surrender dividends or conversion credits to apply to cost of change
 Balance to: Refund Unscheduled Premium

Exercise of Policy Split Option Rider from: Policy _____
 Exercise of Survivor Purchase Option Rider from: Policy _____
 Exercise of Guaranteed Purchase Option Rider from: Policy _____
 As of option date
 Advance Purchase due to: Marriage Birth or legal adoption of child - Date ___ / ___ / _____

3. BASIC COVERAGE TO BE

Product _____ Policy Planned Premium \$ _____
 Face Amount \$ _____ Premium Frequency: (choose one)
 Annual Semi Annual Quarterly Single Pay
 EFT (complete EFT form + attach sample check)
 Death Benefit Option if applicable: List Bill Number _____
 Option 1: Level Face Amount Annual Semi Annual Quarterly Monthly
 Option 2: Face + Accumulated/Policy Value Unscheduled Premium \$ _____

4. BENEFITS/RIDERS (Some riders are not available with all products)

Accidental death – Amount \$ _____ Waiver of Premium/Specified Premium
 Children Term – Amount \$ _____ Waiver of Monthly Deductions/Monthly Policy Charges
 _____ _____

5. CHANGE OF OWNER

Owner Name (If trust, provide name of trust*)	Relationship to Proposed Insured
Primary Resident Street Address	Taxpayer Identification Number
City, State, Zip Code	Date of Birth (If trust, provide date of trust*)
Joint Owner Name	Relationship to Proposed Insured
Primary Resident Street Address	Taxpayer Identification Number
City, State, Zip Code	Date of Birth
Contingent Owner Name	Relationship to Proposed Insured

* Submit copy of trust with this application.

Proposed Insured Name _____

6. BENEFICIARY INFORMATION

Primary Beneficiary	Relationship to Proposed Insured
Contingent Beneficiary	Relationship to Proposed Insured

7. REPLACEMENT

- (a) Is there other life insurance or annuities in force or applied for? Yes No
- (b) Will the insurance applied for with this application replace or affect any of the owner's other life or annuity contracts (including pending coverage provided with a binding receipt)? Yes No
 If yes, list company name(s) and policy number(s) and provide necessary forms: _____
- (c) Is this an Internal Revenue Code section 1035 exchange? Yes No

IF ORIGINAL POLICY WAS ISSUED PRIOR TO 1978 OR IF ORIGINAL ISSUE AGE WAS AGE 0 – 19, PROCEED TO QUESTION 8 TO BE ANSWERED BY THE PROPOSED INSURED. OTHERWISE, SKIP QUESTION 8.

8. TOBACCO USE OF PROPOSED INSURED

Within the past 36 months, have you used any form of tobacco products? Yes No
 If yes, provide details _____

9. SIGNATURE OF PROPOSED INSURED/OWNER

I represent that all statements in this application are true and complete to the best of my knowledge and belief. I understand and agree that these statements are the basis of any insurance issued. If issued, the new policy will be effective as of issuance. The Company agrees to pay any proceeds pursuant to policy terms subject to the acceptance of the proposed owner.

Warning: It is a crime to provide false, misleading, or incomplete information to an insurance company for the purpose of defrauding the company or any other person. Penalties include imprisonment and/or fines and denial of insurance benefits.

Signature of Proposed Insured (If applicable)				
X				
Signature of Owner(s), if other than Proposed Insured. If corporation, an officer other than the Proposed Insured must sign and include officer's title. If joint ownership or Trust, all joint owners/trustees must sign. If signing as a Trustee include 'Trustee' as title.				
X			Title	
X			Title	
X			Title	
Signed at: City	State	Date	Signature of Licensed Agent/Broker/Representative	License Number
X				
Cosignature by resident Licensed Agent/Broker/Representative, if applicable in your state			Date	License Number
X				



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**Life Insurance
 Adjustment
 Application**

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PART A

1. PERSONAL INFORMATION ABOUT THE INSURED

Name (First, Middle, Last)	Policy Number	Date of Birth / /	
Primary Residence Street Address	Social Security Number - -	Birthplace (State, or Country if not U.S.)	
City, State, Zip Code	Driver's License Number	State Issued	
Home Phone Number ()	Occupation		
Work Phone Number ()	Workplace Zip Code		

2. BASIC COVERAGE APPLIED FOR (Face and Premium/Plan must be completed.)

Face Amount to be (excluding riders) \$ _____	Policy Planned Premium \$ _____
Plan to be (AL policies only) _____	Premium Frequency: (Choose One) <input type="checkbox"/> Annual <input type="checkbox"/> Semi Annual <input type="checkbox"/> Quarterly <input type="checkbox"/> Single Pay
Unscheduled Premium \$ _____	<input type="checkbox"/> EFT (complete EFT form + attach sample check)
Premium Duration (number of years) _____	List Bill Number _____ <input type="checkbox"/> Annual <input type="checkbox"/> Semi Annual <input type="checkbox"/> Quarterly <input type="checkbox"/> Monthly

3. BENEFITS/RIDERS – (Some riders are not available with all products)

A = Add C = Cancel D = Decrease I = Increase

A C	A C D I	Amount to be
<input type="checkbox"/> <input type="checkbox"/> Automatic Premium Loan	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Accidental Death Benefit	\$ _____
N/A <input type="checkbox"/> Payor Death or Disability	N/A <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Children Term—Number of Units/Amount	\$ _____
<input type="checkbox"/> <input type="checkbox"/> 20 year Premium Guarantee	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> DPA (based on premium mode)	\$ _____
<input type="checkbox"/> <input type="checkbox"/> Waiver Disability Benefit	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Guaranteed Increase Option (GIO)	\$ _____
<input type="checkbox"/> <input type="checkbox"/> Waiver Mo. Deduct./Policy Charges	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Guaranteed Purchase Option (GPO)	\$ _____
<input type="checkbox"/> <input type="checkbox"/> Waiver Sched./Spec. Premiums	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Salary Increase	\$ _____
<input type="checkbox"/> <input type="checkbox"/> Other _____	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Single Life Term	\$ _____
<input type="checkbox"/> <input type="checkbox"/> Other _____	N/A <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Spouse Term	\$ _____
<input type="checkbox"/> <input type="checkbox"/> Other _____	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Supplemental Benefit	\$ _____
<input type="checkbox"/> <input type="checkbox"/> Other _____	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Other _____	\$ _____

Proposed Insured Name _____

4. CONVERSION OPTIONS

Convert: Policy Rider Extra Protection Option
 Family/Child Term Spouse Term

Convert from Policy Number _____
a. Convert Full Guaranteed Amount
Convert from Policy Number _____
b. Convert \$ _____ with remaining amount
 Continued Canceled

5. OTHER CHANGES

Change Death Benefit Option to:
 Option 1 (Level Face Amount)
 Option 2 (Face plus Accum Value) by:
 Adjusting the current Face Amount (default approach)
 Keeping the current Face Amount
 Change Dividend Option to _____
 Exercise Change of Insured
Name _____
D.O.B. _____ Sex Male Female
Social Security Number _____
 Exercise GIO/GPO* - As of Option Date _____
 Exercise GIO/GPO* Advance Purchase Option
due to: Marriage Birth/Adoption
Date ____ / ____ / ____
 Exercise COL/BVI/SIR/EPSIR/IOR
 Partial Surrender \$ _____
 Cash Apply to Loan Apply to Premium
(Submit Notice of Taxability Withholding & Election)
 Rate Reconsideration
 Change to Nonsmoker/Nontobacco
 Remove Insured from First-to-Die Policy
 Surrender Dividends for cost of change
 Surrender PAPA \$ _____
 Other/Special Instructions _____

***(If purchase option from another policy, write original policy number in Other/Special Instructions)**

6. REINSTATEMENT WITH ADJUSTMENT

WITH back premiums (in conjunction with a policy adjustment)
 WITHOUT back premiums (not available for term products)
Complete (Part B) for insured. Submit Reinstatement Application for all other covered members.

7. CHANGE OF OWNERSHIP

(a) Is there an intention that any group of investors will obtain any right, title, or interest in any policy issued on the life of the Proposed Insured(s) as a result of this application?..... Yes No
If yes, explain. _____
(b) Will you borrow money to pay the premiums for this policy or have someone else pay these premiums for you in return for an assignment of policy values back to them?..... Yes No
If yes, explain and complete required premium financing acknowledgement form. _____

Proposed Insured Name _____

8. OTHER INSURANCE

(a) Is there other life insurance or annuities in force or applied for? Yes No
 (If yes, list all other life insurance or annuities in force or currently being applied for, even if sold, assigned, or viaticated.)

Insured's Name	Company	Amount	Policy Number	Check if Pending	Year Issued	Primary Purpose
		\$		<input type="checkbox"/>		
		\$		<input type="checkbox"/>		
		\$		<input type="checkbox"/>		
		\$		<input type="checkbox"/>		

(b) If coverage is pending, will all pending coverage be accepted? Yes No
 If no, explain. _____

(c) Have you transferred or assigned any right, title, or interest in any life insurance or annuity contract other than absolute assignment for Internal Revenue Code 1035 exchange? Yes No
 If yes, explain. _____

9. REPLACEMENT

(a) Will the insurance applied for with this application replace or affect any of the Owner's other life or annuity contracts (including pending coverage provided with a binding receipt)? Yes No
 If yes, list company name(s) and policy number(s) and provide necessary forms:

(b) Is this an Internal Revenue Code section 1035 exchange? Yes No

**FOR UNDERWRITTEN ADJUSTMENTS, PROCEED TO QUESTIONS 10 and 11.
 FOR NON-UNDERWRITTEN ADJUSTMENTS, CONTINUE TO PART C (PAGE 8).**

10. TOBACCO OR NICOTINE USAGE

In the last ten years have you used any tobacco or nicotine products? Yes No

(Indicate date last used and amount per day)

- a. cigarettes _____
- b. cigars _____
- c. nicotine patch/gum _____
- d. pipe _____
- e. chewing tobacco/snuff _____
- f. other _____

11. MEDICAL QUESTION

Within the last ten years, has any Proposed Insured (includes primary insured, spouse, payor and children) been treated for, or diagnosed as having a heart condition, chest pain, stroke, cancer, diabetes, alcohol abuse or drug dependency? (If yes, explain below) Yes No
 Attach a separate sheet if additional space is needed.

Proposed Insured's Name	Details (including dates and healthcare provider's name/address)
_____	_____
_____	_____
_____	_____
_____	_____



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Adjustment
Application**

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Part C – AGREEMENT/AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

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 the application, including statements by the Proposed Insured in any medical questionnaire that becomes a part of this application, shall be the basis of any insurance issued. I also understand that misrepresentations could mean denial of an otherwise valid claim and rescission of the policy during the contestable period.

I understand that the policy(ies) delivered to me may be from a different issuer than what was listed in the application. I understand and agree that my acceptance of the policy(ies) shall be considered an amendment to this application. Each policy has only one issuing company and that issuer is solely responsible for the obligations under that policy.

When an Adjustment Becomes Effective: I understand and agree that in applying to adjust my policy coverage, any adjustment approved by the Company is effective as of the Adjustment Date shown on the new data pages for the policy, provided that I and the proposed insured (if different than me) sign the Part D of this Adjustment Application and any amendment form, if applicable, and return such forms to the Company within 30 days of the adjustment delivery date.

Limitation of Authority: I understand and agree that no agent, broker, licensed 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 agent, broker, licensed representative, telephone interviewer, medical examiner or other person shall be considered knowledge of the Company unless such fact is stated in the application.

If my employer is the owner and beneficiary on this application: I agree to allow my employer to purchase insurance on my life. I understand that my employer or trustee will have all present and future rights of ownership and will also be the beneficiary of the policy. There is no obligation, on my part, to pay the policy premiums. I acknowledge that as an employee, the employer or trustee has an insurable interest in my life. I understand and agree that my administrators, estate, heirs and assignees have no rights to the policy or any policy proceeds. I understand that the maximum face amount for which I could be insured at the time of issuance is generally not more than 30 times compensation, up to a maximum of \$30,000,000, subject to underwriting guidelines. I further authorize my employer or trustee to increase or decrease the amount of insurance on my life in the future without another consent from me and without further notice to me as long as I am employed by the employer. I consent to and authorize my employer, trustees, or its successors to continue to be the owner and beneficiary of this policy(ies) indefinitely including after the end of my employment by the employer.

AUTHORIZATION (For Underwritten Adjustments Only)

I authorize any insurance (or reinsuring) company, consumer reporting agency, governmental agency, insurance agent, broker, licensed representative, or any other organization, institution or person having personal information (including physical, mental, drug or alcohol use history) regarding me, the named proposed insured, to provide to the Company, its representatives or reinsurers, any such data. I authorize the Company or its representative to conduct a telephone interview in connection with my application for insurance.

I understand and agree to sign any authorization that is required to authorize any doctor, hospital, clinic, health care provider, laboratory, pharmacy benefit manager or any other institution having personal information (including physical, mental, drug or alcohol use history) regarding the named proposed insured to provide the Company, its representatives or reinsurers any such data. I understand that if I refuse to sign an authorization to release my complete medical record, the Company may not be able to process my application for life insurance coverage.

I authorize the Medical Information Bureau (MIB, Inc.) to furnish the above data to the Company, its representative or its reinsurers. I authorize the Company, or its representative 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.

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PART C – AGREEMENT/AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION (CONTINUED)

C.O.D. or Advance Premium Paid:

- This application is C.O.D. and I have not been given any Conditional Receipt with this application.
- I have paid \$ _____ as an advance premium with this application which is no less than one month's advance premium and I have been given the Life Insurance Adjustment Conditional Receipt. In return I have read, understand, and agree to its terms.
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Signatures – Please read all of the above Agreements, Authorizations, and Certification before signing below.

Signature of Proposed Insured (If age 15 or over)				
X				
Signature of Parent (If Proposed Insured is under age 18 and Parent has not signed as Owner)				
X				
Signature of Owner(s), if other than Proposed Insured. If corporation, an officer other than the Proposed Insured must sign and include officer's title. If joint ownership or Trust, all joint owners/trustees must sign. If signing as a Trustee include 'Trustee' as title.				
X			Title	
X			Title	
X			Title	
Signature of Assignee or Irrevocable Beneficiary			Title	
X				
Signed at: City	State	Date	Signature of Licensed Agent/Broker/Representative	License Number
			X	
Cosignature by resident Licensed Agent/Broker/Representative, if applicable in your state			Date	License Number
X				



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I understand that the policy(ies) delivered to me may be from a different issuer than what was listed in the application. I understand and agree that my acceptance of the policy(ies) shall be considered an amendment to this application. Each policy has only one issuing company and that issuer is solely responsible for the obligations under that policy.

When an Adjustment Becomes Effective: I understand and agree that in applying to adjust my policy coverage, any adjustment approved by the Company is effective as of the Adjustment Date shown on the new data pages for the policy, provided that I and the proposed insured (if different than me) sign the Part D of this Adjustment Application and any amendment form, if applicable, and return such forms to the Company within 30 days of the adjustment delivery date.

Limitation of Authority: I understand and agree that no agent, broker, licensed 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 agent, broker, licensed representative, telephone interviewer, medical examiner or other person shall be considered knowledge of the Company unless such fact is stated in the application.

If my employer is the owner and beneficiary on this application: I agree to allow my employer to purchase insurance on my life. I understand that my employer or trustee will have all present and future rights of ownership and will also be the beneficiary of the policy. There is no obligation, on my part, to pay the policy premiums. I acknowledge that as an employee, the employer or trustee has an insurable interest in my life. I understand and agree that my administrators, estate, heirs and assignees have no rights to the policy or any policy proceeds. I understand that the maximum face amount for which I could be insured at the time of issuance is generally not more than 30 times compensation, up to a maximum of \$30,000,000, subject to underwriting guidelines. I further authorize my employer or trustee to increase or decrease the amount of insurance on my life in the future without another consent from me and without further notice to me as long as I am employed by the employer. I consent to and authorize my employer, trustees, or its successors to continue to be the owner and beneficiary of this policy(ies) indefinitely including after the end of my employment by the employer.

AUTHORIZATION (For Underwritten Adjustments Only)

I authorize any insurance (or reinsuring) company, consumer reporting agency, governmental agency, insurance agent, broker, licensed representative, or any other organization, institution or person having personal information (including physical, mental, drug or alcohol use history) regarding me, the named proposed insured, to provide to the Company, its representatives or reinsurers, any such data. I authorize the Company or its representative to conduct a telephone interview in connection with my application for insurance.

I understand and agree to sign any authorization that is required to authorize any doctor, hospital, clinic, health care provider, laboratory, pharmacy benefit manager or any other institution having personal information (including physical, mental, drug or alcohol use history) regarding the named proposed insured to provide the Company, its representatives or reinsurers any such data. I understand that if I refuse to sign an authorization to release my complete medical record, the Company may not be able to process my application for life insurance coverage.

I authorize the Medical Information Bureau (MIB, Inc.) to furnish the above data to the Company, its representative or its reinsurers. I authorize the Company, or its representative 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 agree that this authorization shall be valid for 24 months from the date of this application. 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 a photocopy of this authorization is as valid as the original. I have received a copy of this authorization. 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.

CLIENT COPY

PART C – AGREEMENT/AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION (CONTINUED)

C.O.D. or Advance Premium Paid:

- This application is C.O.D. and I have not been given any Conditional Receipt with this application.
- I have paid \$ _____ as an advance premium with this application which is no less than one month's advance premium and I have been given the Life Insurance Adjustment Conditional Receipt. In return I have read, understand, and agree to its terms.
- I have submitted an Absolute Assignment form with this application and I have been given the Life Insurance 1035 Conditional Receipt. In return I have read, understand, and agree to its terms.

Warning: It is a crime to provide false, misleading, or incomplete information to an insurance company for the purpose of defrauding the company or any other person. Penalties include imprisonment and/or fines and denial of insurance benefits.

CLIENT COPY



Principal Life Insurance Company
 Principal National Life Insurance Company
 Members of Principal Financial Group®

P.O. Box 10431
 Des Moines, IA 50306-0431

**Application for
 Multi-Life Guaranteed
 Issue Life Insurance**

Only one company is the issuer and responsible for obligations of any given policy and is hereinafter referred to as "the Company".

This application is used to apply for guaranteed issue life insurance. A Corporation, Employer, Trust, Association or similar entity typically owns these policies.

This application consists of:

- *Application:* Completed by the owner
- *Census:* A Census identifying each Proposed Insured and other relevant information must be completed. Each Proposed Insured must complete a Consent to be Insured form. Application and Census must have the same date.

Part A: Corporate Information	Part B: Owner Information
1. Corporation Name _____ _____	1. Owner/Trust Name _____ _____
2. Corporation Tax I.D.	2. Owner Tax I.D. if other than corporation. If owner is a Trust, also provide Trust date:
3. Corporation Contact Name	3. Owner/Trust Contact Name
4. Corporation Street Address	4. Primary Owner/Trust Street Address
City State Zip	City State Zip
5. Phone Fax () ()	5. Phone Fax () ()

Part C: Beneficiary

The Owner shall be sole beneficiary unless otherwise specified

Part D: Policy Information

<p>1. Product _____</p> <p>2. Definition of Life Insurance <input type="checkbox"/> Guideline Premium Test (GPT) <input type="checkbox"/> Cash Value Accumulation (CVAT)</p> <p>3. Death Benefit Option: <input type="checkbox"/> Option 1 – Level Face Amount (required if CVAT) <input type="checkbox"/> Option 2 – Face + Accumulated Value <input type="checkbox"/> Option 3 – Face + Premiums Paid</p> <p>4. Policy Date requested _____</p>	<p>5. Optional Benefit Riders: Supplemental Benefit Rider (SBR) <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes" please indicate base/SBR blend on Census.</p> <p>Accounting Benefit Rider (ABR) <input type="checkbox"/> Yes <input type="checkbox"/> No (on available products only)</p> <p>Other _____</p> <p>6. Premium Payment Plan: <input type="checkbox"/> Single Pay <input type="checkbox"/> Quarterly <input type="checkbox"/> Annual <input type="checkbox"/> Monthly <input type="checkbox"/> Semi-Annual <input type="checkbox"/> Other _____</p>
--	--

Part E: Additional Information and Requests

Part F: Other Life Insurance

Is there other life insurance or annuities in force or pending? Yes No

If "yes", please provide details below or attach a census that should include the following: Insured's Name, Company, Amount, Amount PENDING with other Companies, Year of Issue, Product/Purpose (If Key Person, Deferred Compensation, etc.)

Details: _____

Part G: Replacement

Will this insurance replace or affect any other life or annuity contract for any person proposed for coverage (including pending coverage provided by a binding receipt)? Yes No

If "yes", enclose replacement forms (if applicable) and provide company name(s) and policy number(s): _____

If coverage is PENDING with other companies, will all pending coverage be accepted? Yes No

Explain _____

Part H: Actively at Work

Have all Proposed Insureds been actively at work full time (30 hours or more per week) at their usual place of business on the date of the Census and have not missed more than five consecutive days in the past 90 days because of medical reasons such as illness or injury?

Yes No If No, please explain: _____

("the Company" means Principal Life Insurance Company or Principal National Life Insurance Company)

Taxpayer Identification Number Certification: As applicant of this contract, I certify under penalties of perjury:

- 1. The taxpayer identification number shown on this application is correct.
- 2. I am not subject to IRS backup withholding.

Note: Check this box if you are currently subject to backup withholding.

Check this box if the Internal Revenue Service has notified you that you are **not** subject to the provisions of this law.

The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.

Otherwise, your signature on this application is certification that the taxpayer identification number on this application is true, correct, and complete.

Statements in Application: I represent that all statements in the application are true and complete, to the best of my knowledge and belief. I understand that misrepresentations can mean denial of an otherwise valid claim and rescission of the policy during the contestable period.

Fraud Notice Warning: It is a crime to provide false, misleading or incomplete information to an insurance company for the purpose of defrauding the company or any other person. Penalties include imprisonment and/or fines and denial of insurance benefits.

When Insurance Effective: Except as may be provided by Temporary Insurance Agreement signed by me, I agree that no insurance shall take effect unless and until the Policy has been delivered to and accepted by me; and, the initial premium is paid during the lifetime and prior to any change in insurability of the Proposed Insureds.

Limitation of Authority: I agree that no agent, broker, or licensed representative of the Company 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 on this Application and Census, that becomes a part of this application, may not be waived.

Signed at: City _____ State _____ Date _____

Print Name and title of Applicant/Owner/Authorized officer

Signature of Applicant/Owner/Authorized Officer

Print name of Agent/Broker/Licensed Representative

Signature of Agent/Broker/Licensed Representative

List Individuals authorized to sign on behalf of the Owner.

Print Name

Print Name

Title

Title

Signature

Signature

Census

Corporation Name

Date

Proposed Insured		Birth Date	Sex	Soc. Sec. Number	Initial Base Policy DB	SBR Amount	Total DB	1035 Rollover	Planned Premium	Smoker Y/N	Actively at work Y/N
Last	First										
			<input type="checkbox"/> M <input type="checkbox"/> F							<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
			<input type="checkbox"/> M <input type="checkbox"/> F							<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
			<input type="checkbox"/> M <input type="checkbox"/> F							<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
			<input type="checkbox"/> M <input type="checkbox"/> F							<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
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			<input type="checkbox"/> M <input type="checkbox"/> F							<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N



Principal Life Insurance Company
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P.O. Box 10431
 Des Moines, IA 50306-0431

**Adjustment Application
 for Multi-Life Life
 Insurance Policy(s)**

Only one company is the issuer and responsible for obligations of any given policy and is hereinafter referred to as "the Company".

This application is used to make changes or adjustments to existing policy(s). A new census with requested changes must be included with all adjustment transactions. New proposed insureds will need to complete Consent to be Insured form.

Part A: Corporate Information	
1. Corporation Name	2. Policy Number(s)

Part B: Reinstatement
 Reinstatement: Your Policy date will remain the original Policy Date.

Part C: Change Face Amount (base plan) <input type="checkbox"/> Increase Face Amount <input type="checkbox"/> Decrease Face Amount (may be made after first policy year)	Part D: Riders A = Add C = Cancel D = Decrease I = Increase Riders <table style="width:100%"> <tr> <td></td> <td style="text-align:center">A</td> <td style="text-align:center">C</td> <td style="text-align:center">D</td> <td style="text-align:center">I</td> </tr> <tr> <td>Supplemental Benefit Rider (SBR).</td> <td style="text-align:center"><input type="checkbox"/></td> <td style="text-align:center"><input type="checkbox"/></td> <td style="text-align:center"><input type="checkbox"/></td> <td style="text-align:center"><input type="checkbox"/></td> </tr> <tr> <td>Other _____</td> <td style="text-align:center"><input type="checkbox"/></td> <td style="text-align:center"><input type="checkbox"/></td> <td style="text-align:center"><input type="checkbox"/></td> <td style="text-align:center"><input type="checkbox"/></td> </tr> </table>		A	C	D	I	Supplemental Benefit Rider (SBR).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	A	C	D	I												
Supplemental Benefit Rider (SBR).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>												
Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>												
Part E: Change Death Benefit Option (on or after the first policy anniversary) <input type="checkbox"/> From Option 3 (face + premium paid) to Option 1 (Level Face Amount) <input type="checkbox"/> From Option 3 (face + premium paid) to Option 2 (Face + Accumulated Value) <input type="checkbox"/> From Option 2 (Face + Accumulated Value) to Option 1 (Level Face Amount) <input type="checkbox"/> From Option 1 (Level Face Amount) to Option 2 (Face + Accumulated Value)	Part F: Change Premium payment plan To: <input type="checkbox"/> Annual <input type="checkbox"/> Semi-Annual <input type="checkbox"/> Quarterly <input type="checkbox"/> Monthly <input type="checkbox"/> <u>Unscheduled Premium</u> _____ <input type="checkbox"/> <u>Other</u> _____ _____ _____ _____															

Part G: Other Life Insurance

Is there other life insurance or annuities in force or pending? Yes No

If "yes", please provide details below or attach a census that should include the following: Insured's Name, Company, Amount, Amount PENDING with other Companies, Year of Issue, Product/Purpose (If Key Person, Deferred Compensation, etc.)

Details: _____

Part H: Replacement

Will this insurance replace or affect any other life or annuity contract for any person proposed for coverage (including pending coverage provided by a binding receipt)? Yes No

If "yes", enclose replacement forms (if applicable) and provide company name(s) and policy number(s): _____

If coverage is PENDING with other companies, will all pending coverage be accepted? Yes No

Explain _____

Part I: Change of Insured

Exercise Change of Insured *Consent form(s) required for new insured(s)*

From:				To:		
Policy No.	Name	Date of Birth	Soc. Sec. No.	Name	Date of Birth	Soc. Sec. No.
_____	_____	_____	_____	_____	_____	_____

Attach new census with proposed new insureds.
Attach separate page if changing more than two insureds.

Part J: Partial Surrenders

- Partial Surrenders maintaining face amount
- Partial Surrenders decreasing face amount. (For variable products use **Policy Values Request form**)

Part K: Actively at Work

Have all Proposed Insureds been actively at work full time (30 hours or more per week) at their usual place of business on the date of the Census and have not missed more than five consecutive days in the past 90 days because of medical reasons such as illness or injury?

Yes No If No, please explain: _____

Part L: Additional Information and Requests

("the Company" means Principal Life Insurance Company or Principal National Life Insurance Company)

Taxpayer Identification Number Certification: As applicant of this contract, I certify under penalties of perjury:

1. The taxpayer identification number shown on this application is correct.
2. I am not subject to IRS backup withholding.

Note: Check this box if you are currently subject to backup withholding.

Check this box if the Internal Revenue Service has notified you that you are **not** subject to the provisions of this law.

The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.

Otherwise, your signature on this application is certification that the taxpayer identification number on this application is true, correct, and complete.

Statements in Application: I represent that all statements in the application are true and complete, to the best of my knowledge and belief. I understand that misrepresentations can mean denial of an otherwise valid claim and rescission of the policy during the contestable period.

Fraud Notice Warning: It is a crime to provide false, misleading or incomplete information to an insurance company for the purpose of defrauding the company or any other person. Penalties include imprisonment and/or fines and denial of insurance benefits.

When Adjustments to existing plans are effective: Except as provided under a Temporary Insurance Agreement signed by me, I agree that no adjustments are effective unless and until (1) new data pages issued on this application have been delivered and accepted by me and any required premium paid; and (2) prior to any change in insurability of the Insured or Proposed Insured(s).

Limitation of Authority: I agree that no agent, broker, or licensed representative of the Company 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 on this Application and Census, that becomes a part of this application, may not be waived.

Signed at: City _____ State _____ Date _____

Print Name and title of Applicant/Owner/Authorized officer _____

Signature of Applicant/Owner/Authorized Officer _____

Print name of Agent/Broker/Licensed Representative _____

Signature of Agent/Broker/Licensed Representative _____

List Individuals authorized to sign on behalf of the Owner.

Print Name _____

Print Name _____

Title _____

Title _____

Signature _____

Signature _____

Census

Corporation Name								Date		
Proposed Insured		Birth Date	Sex	Soc. Sec. Number	Initial Base Policy DB	SBR	Total DB	Planned Premium	Smoker Y/N	Actively at work Y/N
Last	First									
			<input type="checkbox"/> M <input type="checkbox"/> F						<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
			<input type="checkbox"/> M <input type="checkbox"/> F						<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
			<input type="checkbox"/> M <input type="checkbox"/> F						<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
			<input type="checkbox"/> M <input type="checkbox"/> F						<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
			<input type="checkbox"/> M <input type="checkbox"/> F						<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
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			<input type="checkbox"/> M <input type="checkbox"/> F						<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
			<input type="checkbox"/> M <input type="checkbox"/> F						<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N



Principal Life Insurance Company
Principal National Life Insurance Company
 Members of Principal Financial Group®

P.O. Box 10431
 Des Moines, IA 50306-0431

**Life Insurance
 Conditional
 Receipt**

Only one company is the issuer and responsible for obligations of any given policy and is hereinafter referred to as "the Company".

(In this Receipt, "we", "us", "our", or "the Company" is the Company which issues the policy, Principal Life Insurance Company or Principal National Life Insurance Company, respectively. "Absolute Assignment" is our Absolute Assignment to Effect a Section 1035(a) Exchange form.)

Name of Proposed Insured(s)	Advance payment of: \$	Date of Application:
-----------------------------	---------------------------	----------------------

AUTHORITY:

This Receipt is not a "binder." No agent, broker, licensed representative, medical examiner, or telephone interviewer may accept risks, determine insurability or bind the Company in any way. No agent, broker, or licensed 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 agent, broker, or licensed representative has **NO AUTHORITY** to accept any premium or to issue this Receipt: if it is apparent that any **Condition Precedent** to coverage under this Receipt is not or cannot be satisfied. **This Conditional Receipt shall be ineffective if issued without authority. Only the Home Office, and not the agent, broker, or licensed representative, has authority to modify any provisions of this Receipt.**

TERMS AND CONDITIONS:

The Company will pay a death benefit to the beneficiary named in the Application if the proposed insured or the surviving Proposed Insured under survivorship life insurance dies while this Conditional Receipt is in effect, subject to the terms and conditions set out below.

1. CONDITIONS PRECEDENT

All the following conditions must be fulfilled exactly. Otherwise there is NO insurance under this Receipt and the Receipt is void:

- a) On the Start Date, all Proposed Insureds must be living and insurable, as determined by our underwriters under our underwriting guidelines. If a condition affecting such insurability existed in fact on the Start Date, it shall be considered in the determination of insurability.
- b) The premium deposit must be at least one full month's premium for each policy applied for.
- c) If the premium deposit is paid at the time the Application is signed, then this Receipt must be issued at the same time as the Application.
- d) The premium deposit must be received in our Home Office and must be honored on first presentment for payment.

2. AMOUNT OF COVERAGE

The amount of insurance provided by this Receipt shall be that applied for on the Application, subject to all the **LIMITATIONS** set forth in this Receipt, and will be the lesser of:

- a) The amount of all death benefits applied for in the Application, including any accidental or supplemental death benefits, if applicable, or
- b) \$1,000,000 if the Proposed Insured is insurable on a standard or more favorable basis, or
- c) \$100,000 if the Proposed Insured is insurable on a basis less favorable than standard, or
- d) \$500,000 per company if the Proposed Insured is insurable on a standard or more favorable basis, and has an application with Conditional Receipt coverage pending with each of Principal Life Insurance Company and Principal National Life Insurance Company, or
- e) \$50,000 per company if the Proposed Insured is insurable on a basis less favorable than standard and has an application with Conditional Receipt coverage with each of Principal Life Insurance Company and Principal National Life Insurance Company.

This total death benefit limit applies to all insurance applied for under this and any current Applications to the Company and any other Conditional Receipts that may be in effect with Principal Life Insurance Company and/or Principal National Life Insurance Company.

3. DATE COVERAGE BEGINS

If all of the **Conditions Precedent** set forth in this Receipt are fulfilled exactly, insurance under this Receipt takes 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 and all necessary supplements, completion of the telephone application interview, if applicable, and completion of any medical exams and tests required by our published rules.

If premium is submitted after the initial Application is signed and dated, then updated evidence of insurability, subject to our current underwriting guidelines and completion of all our initial Application requirements, is required in order to have insurance under this Receipt. The Start Date would be the earliest date upon which all requirements are completed.

4. DATE COVERAGE ENDS

Any insurance provided by this Receipt ends on the **Stop Date**, which is the **earliest** of:

- a) 75th day after the Start Date;
- b) the date we mail the proposed owner a premium refund and a notice that we will not consider the Application on a prepaid basis;
- c) the date we mail the proposed owner a premium refund and a notice that no policy will be issued on the Application;
- d) when policy coverage becomes effective;
- e) the date a policy is presented to the proposed owner (whether or not accepted by the proposed owner);
- f) the date an Absolute Assignment is received by the Current Insurer(s) and honored on first presentment.

5. HEALTH AND INSURABILITY

This Receipt does not commit Principal Life Insurance Company or Principal National Life Insurance Company to issue any policy. However, in determining whether to issue this policy and on what terms, we will consider no changes in a Proposed Insured's health or insurability occurring between the Start Date and the Stop Date. We have until policy coverage becomes effective to make this determination.

6. LIMITATIONS

- a) **Our Liability:** Except as limited by this Receipt, our liability is governed by the terms of the policy(ies) applied for.
- b) **Suicide:** No death benefit is payable under this Receipt if the Proposed Insured dies by suicide while sane or insane. In such case, our sole liability shall be to pay the premium we received to the named beneficiary(ies).
- c) **Misrepresentation:** No benefit is payable under this Receipt 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. No knowledge of any fact on the part of any agent, broker, licensed representative, medical examiner, telephone interviewer or other person shall be considered knowledge of the Company unless such fact is stated in the Application.
- d) **Survivorship:** For Survivorship Life insurance, no death benefit will be paid under this Receipt unless both Proposed Insureds have died.
- e) **Other:** If any provision of this Receipt is unenforceable under state law, all other terms and conditions shall continue in full force and effect.

7. DEATH PROCEEDS

If an event giving rise to a claim occurs at any time before the Stop Date of this Receipt, coverage will be considered solely under this Receipt even if a policy is issued.

If an event giving rise to a claim occurs at any time after the Stop Date of this Receipt but before policy coverage becomes effective, then the Company shall incur no liability under the Receipt or the Policy even if a policy is issued.

8. PREMIUMS

If a policy is issued from the Application bearing the same date listed on this Receipt and 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 into force but a benefit is paid under this Receipt, we will keep the premium deposit. If no policy is put into force and no benefit is paid under this Receipt, the premium deposit will be refunded. **ALL PREMIUM CHECKS MUST BE MADE PAYABLE TO THE COMPANY AS INDICATED ON PAGE ONE OF THE APPLICATION – DO NOT MAKE CHECK PAYABLE TO THE AGENT OR LEAVE THE CHECK PAYEE BLANK.**



Principal Life Insurance Company
Principal National Life Insurance Company
 Members of Principal Financial Group®

P.O. Box 10431
 Des Moines, IA 50306-0431

Life Insurance
1035 Conditional
Receipt

Only one company is the issuer and responsible for obligations of any given policy and is hereinafter referred to as "the Company".

In this Receipt, "we", "us", "our", or "the Company" is the Company which issues the policy, Principal Life Insurance Company or Principal National Life Insurance Company, respectively. "Absolute Assignment" is our Absolute Assignment to Effect a Section 1035(a) Exchange form, and "Additional Coverage" and "New Data Pages" refer to Additional Coverage and New Data Pages for Life Insurance Adjustment Applications.

Name of Proposed Insured(s)	Date of Application:
-----------------------------	----------------------

AUTHORITY:

This Receipt is not a "binder." No agent, broker, licensed representative, medical examiner, or telephone interviewer may accept risks, determine insurability or bind the Company in any way. No agent, broker, or licensed representative may waive or change any terms of the Receipt, or of the insurance applied for, or any other rights of the Company.

The agent, broker, or licensed representative has **NO AUTHORITY** to accept an Absolute Assignment or to issue this Receipt: if it is apparent that any **Condition Precedent** to coverage under this Receipt is not or cannot be satisfied. **This Conditional Receipt shall be ineffective if issued without authority. Only the Home Office, and not the agent, broker, or licensed representative, has authority to modify any provisions of this Receipt.**

This Receipt does not apply to any policy coverage already in effect, any non-underwritten coverage applied for, any guaranteed conversion privilege, guaranteed purchase or increase option, a request for reinstatement or request for a change of insured, and the agent, broker, or licensed representative has **NO AUTHORITY** to issue this Receipt in such cases.

TERMS AND CONDITIONS:

The Company will pay a death benefit to the beneficiary named in the Application (or named in the policy if Adjustment Application) if the proposed insured or the surviving proposed insured under survivorship life insurance dies while this Conditional Receipt is in effect, subject to the terms and conditions set out below.

1. CONDITIONS PRECEDENT

All the following conditions must be fulfilled exactly. Otherwise there is NO insurance under this Receipt and the Receipt is void:

- a) On the Start Date, all Proposed Insureds must be living and insurable, as determined by our underwriters under our underwriting guidelines. If a condition affecting such insurability existed in fact on the Start Date, it shall be considered in the determination of insurability.
- b) Any advance proceeds applied as premium deposit must be at least one full month's premium for each policy applied for.
- c) If the Absolute Assignment is signed at the time the Application is signed, then this Receipt must be issued at the same time as the Application. If Absolute Assignment is submitted after the initial Application is signed and dated, then this Receipt must be issued at the same time as Absolute Assignment.
- d) The Absolute Assignment must be received in our Home Office and must be honored by the Current Insurer(s) on first presentment for payment.
- e) If the Absolute Assignment is submitted after the initial Application is signed and dated then updated evidence of insurability, subject to our current underwriting guidelines and completion of all routine medical requirements, is required.

2. AMOUNT OF COVERAGE

The amount of insurance provided by this Receipt shall be subject to all the **LIMITATIONS** set forth in this Receipt and will be the lesser of:

- a) The amount of all death benefits applied for in the Application, including any accidental or supplemental death benefits, if applicable, or
- b) The amount of death proceeds paid to the Company under the Absolute Assignment. If the Company receives proceeds in excess of the amount applied for, the excess proceeds will be paid to the beneficiary named in the Application.

This total death benefit limit applies to all insurance applied for under this and any current Applications to the Company and any other Conditional Receipts that may be in effect with Principal Life Insurance Company or Principal National Life Insurance Company.

3. DATE COVERAGE BEGINS

If all of the **Conditions Precedent** set forth in this Receipt are fulfilled exactly, insurance under this Receipt takes effect on the **Start Date**. The Start Date is the date the Current Insurer(s) receive(s) and honor(s) the Absolute Assignment on first presentment.

4. DATE COVERAGE ENDS

Any insurance provided by this Receipt ends on the **Stop Date**, which is the **earliest** of:

- a) the date we mail the proposed owner the voided Absolute Assignment and a notice that we will not consider the Application on a prepaid basis;
- b) the date we mail the proposed owner the voided Absolute Assignment and a notice that the Absolute Assignment was not honored;
- c) when policy coverage becomes effective;
- d) the date a policy (or Additional Coverage) is presented to the proposed owner (whether or not accepted by the proposed owner).

5. HEALTH AND INSURABILITY

This Receipt does not commit Principal Life Insurance Company or Principal National Life Insurance Company to issue any policy (or Additional Coverage). However, in determining whether to issue this policy (or Additional Coverage) and on what terms, we will consider no changes in a Proposed Insured's health or insurability occurring between the Start Date and the Stop Date. We have until policy coverage (or Additional Coverage) becomes effective to make this determination.

6. LIMITATIONS

- a) **Our Liability:** Except as limited by this Receipt, our liability is governed by the terms of the policy(ies) applied for (or policy(ies) being adjusted if Adjustment Application).
- b) **Suicide:** No death benefit is payable under this Receipt if the Proposed Insured dies by suicide while sane or insane. In such case, our sole liability shall be to pay the premium we received to the named beneficiary(ies).
- c) **Misrepresentation:** No benefit is payable under this Receipt 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. No knowledge of any fact on the part of any agent, broker, licensed representative, medical examiner, telephone interviewer or other person shall be considered knowledge of the Company unless such fact is stated in the Application.
- d) **Survivorship:** For Survivorship Life insurance, no death benefit will be paid under this Receipt unless both Proposed Insureds have died.
- e) **Other:** If any provision of this Receipt is unenforceable under state law, all other terms and conditions shall continue in full force and effect.

7. DEATH PROCEEDS

If an event giving rise to a claim occurs at any time before the Stop Date of this Receipt, coverage will be considered solely under this Receipt even if a policy (or Additional Coverage) is issued.

If an event giving rise to a claim occurs at any time after the Stop Date of this Receipt but before policy coverage becomes effective, then the Company shall incur no liability under the Receipt or the Policy even if a policy (or Additional Coverage) is issued.

8. PREMIUMS

If a policy (or Additional Coverage) is issued from the Application bearing the same date listed on this Receipt and is accepted by the proposed owner, we will apply any and all advance proceeds including 1035(a) exchange proceeds to the first premium due for such policy (or Additional Coverage). If a death benefit is paid under this Receipt, then the premium deposit shall be the 1035(a) exchange proceeds. If no policy (or Additional Coverage) is put into force and no benefit is paid under this Receipt, then any advance proceeds will be refunded.



Principal Life Insurance Company
Principal National Life Insurance Company
Members of Principal Financial Group®

P.O. Box 10431
 Des Moines, IA 50306-0431

**Supplemental
 Statement**

Only one company is the issuer and responsible for obligations of any given policy and is hereinafter referred to as "the Company".

Name _____

Date of Birth	Date Application Signed	File Number(s)
---------------	-------------------------	----------------

Yes No 1. Have you had any illness or injury or consulted a member of the medical profession since the date of application? If yes, provide details. _____

Yes No 2. (Disability Insurance only) Have you changed jobs or employment since the date of application, or do you intend to change jobs or employment within the next 6 months? If yes, provide details.

Yes No 3. Have you applied for other life, disability or health insurance since the date of application? If yes, please provide details including carrier name, amount applied for, action taken, and the intent of the coverage that was applied for with the other carrier. _____

Warning: It is a crime to provide false, misleading, or incomplete information to an insurance company for the purpose of defrauding the company or any other person. Penalties include imprisonment and/or fines and denial of insurance benefits.

I represent that all statements recorded above 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 these statements will become part of my application and any policy issued on it.

Signature of Proposed Insured (If age 15 or over) X		
Signature of Parent (If Proposed Insured is under age 18) X		
Date	Signature of Licensed Agent/Broker/Representative X	License Number



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**Life Insurance
 Adjustment
 Conditional
 Receipt**

Only one company is the issuer and responsible for obligations of any given policy and is hereinafter referred to as "the Company".

(In this Receipt, "we", "us", "our", or "the Company" is the Company which issues the policy, Principal Life Insurance Company or Principal National Life, respectively. "Absolute Assignment" is our Absolute Assignment to Effect a Section 1035(a) Exchange form.)

Name of Proposed Insured(s)	Advance payment of: \$	Date of Application:
-----------------------------	---------------------------	----------------------

AUTHORITY:

This Receipt is not a "binder." No agent, broker, licensed representative, medical examiner, or telephone interviewer may accept risks, determine insurability or bind the Company in any way. No agent, broker, or licensed 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 agent, broker, or licensed representative has **NO AUTHORITY** to accept any premium or to issue this Receipt: if it is apparent that any **Condition Precedent** to coverage under this Receipt is not or cannot be satisfied. **This Conditional Receipt shall be ineffective if issued without authority. Only the Home Office, and not the agent broker, or licensed representative, has authority to modify any provisions of this Receipt.**

This Receipt applies only to underwritten increases in insurance and the addition of underwritten riders. This receipt does not apply to a request for reinstatement or to a change of insured, and the agent, broker, or licensed representative has **NO AUTHORITY** to issue this Receipt in such cases.

TERMS AND CONDITIONS:

The Company will pay a death benefit to the beneficiary named in the Application if the Proposed Insured or the surviving Proposed Insured under survivorship life insurance dies while this Conditional Receipt is in effect, subject to the terms and conditions set out below.

1. CONDITIONS PRECEDENT

All the following conditions must be fulfilled exactly. Otherwise there is NO insurance under this Receipt and the Receipt is void:

- a) On the Start Date, all Proposed Insureds must be living and insurable, as determined by our underwriters under our underwriting guidelines. If a condition affecting such insurability existed in fact on the Start Date, it shall be considered in the determination of insurability.
- b) The premium deposit must be at least one full month's premium for the policy with the adjustment(s) applied for. For policies with a planned periodic premium, the premium deposit is that amount calculated by the Company and provided to the policyowner in connection with the policyowner's request.
- c) If the premium deposit is paid at the time the Application is signed, then this Receipt must be issued at the same time as the Application.
- d) The premium deposit must be received in our Home Office and must be honored on first presentment for payment.
- e) For exercise of the Advance Option Privilege under the Guaranteed Purchase Option rider or the Guaranteed Increase Option rider, the Application must be made within 90 days after (a) date of marriage of the Proposed Insured, (b) birth of a live-born child of the proposed insured, or (c) legal adoption of a child.

2. AMOUNT OF COVERAGE

The amount of insurance provided by this Receipt shall be the additional **underwritten** coverage applied for on the Application, subject to all the **LIMITATIONS** set forth in this Receipt, and will be the lesser of:

- a) The amount of all death benefits applied for in the Application, including any accidental or supplemental death benefits, if applicable, or
- b) \$1,000,000 if the Proposed Insured is insurable on a standard or more favorable basis, or
- c) \$100,000 if the Proposed Insured is insurable on a basis less favorable than standard, or
- d) \$500,000 per company if the Proposed Insured is insurable on a standard or more favorable basis, and has an application with Conditional Receipt coverage pending with each of Principal National Life Insurance Company and Principal Life Insurance Company, or
- e) \$50,000 per company if the Proposed Insured is insurable on a basis less favorable than standard and has an application with Conditional Receipt coverage with each of Principal National Life Insurance Company and Principal Life Insurance Company.

This total death benefit limit applies to all insurance applied for under this and any current Applications to the Company and any other Conditional Receipts that may be in effect with Principal Life Insurance Company or Principal National Life.

3. DATE COVERAGE BEGINS

If all of the **Conditions Precedent** set forth in this Receipt are fulfilled exactly, insurance under this Receipt takes 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 and all necessary supplements, completion of the telephone application interview, if applicable, and completion of any medical exams and tests required by our published rules.

If premium is submitted after the initial Application is signed and dated, then updated evidence of insurability, subject to our current underwriting guidelines and completion of all our initial Application requirements, is required in order to have insurance under this Receipt. The Start Date would be the earliest date upon which all requirements are completed.

4. DATE COVERAGE ENDS

Any insurance provided by this Receipt ends on the **Stop Date**, which is the **earliest** of:

- a) 75th day after the Start Date;
- b) the date we mail the owner a premium refund and a notice that we will not consider the Application on a prepaid basis;
- c) the date we mail the owner a premium refund and a notice that the additional coverage applied for will not be issued;
- d) when additional policy coverage becomes effective;
- e) the date an Absolute Assignment is received by the Current Insurer(s) and honored on first presentment.

5. HEALTH AND INSURABILITY

This Receipt does not commit Principal Life Insurance Company or Principal National Life Insurance Company to issue any additional coverage. However, in determining whether to issue such coverage and on what terms, we will consider no changes in a Proposed Insured's health or insurability occurring between the Start Date and the Stop Date. We have until additional policy coverage becomes effective to make this determination.

6. LIMITATIONS

- a) **Our Liability:** Except as limited by this Receipt, our liability is governed by the terms of the policy(ies) being adjusted.
- b) **Suicide:** No death benefit is payable under this Receipt if the Proposed Insured dies by suicide while sane or insane. In such case, our sole liability shall be to pay the premium we received to the named beneficiary(ies).
- c) **Misrepresentation:** No benefit is payable under this Receipt 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. No knowledge of any fact on the part of any agent, broker, licensed representative, medical examiner, telephone interviewer or other person shall be considered knowledge of the Company unless such fact is stated in the Application.
- d) **Survivorship:** For Survivorship Life insurance, no death benefit will be paid under this Receipt unless both Proposed Insureds have died.
- e) **Other:** If any provision of this Receipt is unenforceable under state law, all other terms and conditions shall continue in full force and effect.

7. DEATH PROCEEDS

If an event giving rise to a claim occurs at any time before the Stop Date of this Receipt, coverage will be considered solely under this Receipt even if additional coverage is issued.

If an event giving rise to a claim occurs at any time after the Stop date of this Receipt but before additional policy coverage becomes effective, then the Company shall incur no liability under the Receipt or any additional liability under the Policy even if additional policy coverage is issued.

8. PREMIUMS

If additional policy coverage is issued from the Application bearing the same date listed on this Receipt and is accepted by the owner, we will apply the premium deposit to the first premium due for such additional policy coverage. If no additional policy coverage is put into force but a benefit is paid under this Receipt, we will keep the premium deposit. If no additional policy coverage is put into force and no benefit is paid under this Receipt, the premium deposit will be refunded. **ALL PREMIUM CHECKS MUST BE MADE PAYABLE TO THE COMPANY AS INDICATED ON PAGE ONE OF THE ADJUSTMENT APPLICATION – DO NOT MAKE CHECK PAYABLE TO THE AGENT OR LEAVE THE CHECK PAYEE BLANK.**



Principal Life Insurance Company
 Principal National Life Insurance Company
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 Des Moines, IA 50306-0431

**Worksite Term
 Life Insurance
 Application**

Only one company is the issuer and responsible for obligations of any given policy and is hereinafter referred to as "the Company".

1. PERSONAL INFORMATION ABOUT THE PROPOSED INSURED

Name (First, Middle, Last)	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth / /
Primary Residence Street Address	Social Security Number - -	Birthplace (State, or Country if not U.S.)
City, State, Zip Code	Driver's License Number	State Issued
Home Phone Number ()	Occupation	Annual Income
Work Phone Number ()	Workplace Zip Code	

2. TERM COVERAGE APPLIED FOR

Product _____	Policy Planned Premium \$ _____
Face Amount \$ _____	Premium Frequency: (choose one) <input type="checkbox"/> EFT* <input type="checkbox"/> Quarterly <input type="checkbox"/> Semi Annual <input type="checkbox"/> Annual

***Authorization for Withdrawals and/or Electronic Funds Transfer:** By providing my financial institution name and account information, I hereby authorize the Company to debit my checking/savings account as needed to pay premiums. Notification of cancellation of this authorization must occur within 10 working days of the transaction by the party canceling the authorization.

Financial Institution Name	Financial Institution Phone Number ()
Financial Institution Address	Account Holder's Name
Transit and Routing Number	Account Number

Checking (attach a voided check) Savings (attach a deposit slip)

3. BENEFICIARY INFORMATION

Primary Beneficiary	Relationship to Proposed Insured
Contingent Beneficiary	Relationship to Proposed Insured

4. OWNERSHIP INFORMATION (If other than Proposed Insured)

Owner Name	Relationship to Proposed Insured
Primary Residence Street Address	Taxpayer Identification Number
City, State, Zip Code	Date of Birth
Contingent Owner Name	Relationship to Proposed Insured

5. OTHER INSURANCE

Is there other life insurance or annuities in force or applied for? Yes No
 If yes, list total amount of life insurance and total amount of annuities in force or applied for. _____

AGREEMENT/AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

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 the application shall be the basis of any insurance issued. I also understand that misrepresentations can mean denial of an otherwise valid claim and rescission of the policy during the contestable period.

I understand that the policy(ies) delivered to me may be from a different issuer than what was listed in the application. I understand and agree that my acceptance of the policy(ies) shall be considered an amendment to this application. Each policy has only one issuing company and that issuer is solely responsible for the obligations under that policy.

Warning: It is a crime to provide false, misleading, or incomplete information to an insurance company for the purpose of defrauding the company or any other person. Penalties include imprisonment and/or fines and denial of insurance benefits.

When Policy Coverage Becomes Effective: I understand and agree that if a policy is issued, policy coverage will become effective as of issuance. The Company agrees to pay any proceeds pursuant to policy terms subject to the acceptance of the proposed owner.

Limitation of Authority: I understand and agree that no agent, broker, or licensed representative has any authority to determine insurability, or to make, change or discharge any contract, or to waive any of the Company's rights.

AUTHORIZATION

I authorize any insurance (or reinsuring) company, consumer reporting agency, governmental agency, insurance agent, broker, licensed representative, or any other organization, institution or person having personal information (including physical, mental, drug or alcohol use history) regarding me, the named proposed insured, to provide to the Company, its representatives or reinsurers, any such data. I authorize the Company or its representative to conduct a telephone interview in connection with my application for insurance.

I authorize the Medical Information Bureau (MIB, Inc.) to furnish the above data to the Company, its representative or its reinsurers. I authorize the Company or its representative 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. I understand that the data obtained by use of this authorization will be used by the Company to determine eligibility for insurance.

I agree that this authorization shall be valid for 24 months from the date of this application. 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 a photocopy of this authorization is as valid as the original. I have received a copy of this authorization. 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.

Advance Premium Paid: I have paid an advance premium with this application and I have been given the Life Insurance Conditional Receipt. In return I have read, understand, and agree to its terms.

Owner Taxpayer Identification Number Certification: As proposed owner of this contract, I certify under penalties of perjury: (1) The taxpayer identification number shown on this application is correct, (2) I am not subject to IRS backup withholding, and (3) I am a U.S. person (which includes a U.S. resident alien). If subject to backup withholding complete W-9. If not a U.S. person complete W-8. **The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.**

Signatures – Please read all of the above Agreements, Authorizations, and Certification before signing below.

Signature of Proposed Insured X	Signature of Owner, if other than Proposed Insured, and Title X	
Signed at: City	State	Date

Producer Section

Do you know, or have reason to believe, replacement is or may be involved in this transaction? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Signature of Licensed Agent/Broker/Representative X	Date	License Number
Cosignature by resident Licensed Agent/Broker/Representative, if applicable X	Date	License Number



Principal Life Insurance Company
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P.O. Box 10431
Des Moines, IA 50306-0431

**Worksite Term
Life Insurance
Application**

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AGREEMENT/AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

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 the application shall be the basis of any insurance issued. I also understand that misrepresentations can mean denial of an otherwise valid claim and rescission of the policy during the contestable period.

I understand that the policy(ies) delivered to me may be from a different issuer than what was listed in the application. I understand and agree that my acceptance of the policy(ies) shall be considered an amendment to this application. Each policy has only one issuing company and that issuer is solely responsible for the obligations under that policy.

Warning: It is a crime to provide false, misleading, or incomplete information to an insurance company for the purpose of defrauding the company or any other person. Penalties include imprisonment and/or fines and denial of insurance benefits.

When Policy Coverage Becomes Effective: I understand and agree that if a policy is issued, policy coverage will become effective as of issuance. The Company agrees to pay any proceeds pursuant to policy terms subject to the acceptance of the proposed owner.

Limitation of Authority: I understand and agree that no agent, broker, or licensed representative has any authority to determine insurability, or to make, change or discharge any contract, or to waive any of the Company's rights.

AUTHORIZATION

I authorize any insurance (or reinsuring) company, consumer reporting agency, governmental agency, insurance agent, broker, licensed representative, or any other organization, institution or person having personal information (including physical, mental, drug or alcohol use history) regarding me, the named proposed insured, to provide to the Company, its representatives or reinsurers, any such data. I authorize the Company or its representative to conduct a telephone interview in connection with my application for insurance.

I authorize the Medical Information Bureau (MIB, Inc.) to furnish the above data to the Company, its representative or its reinsurers. I authorize the Company or its representative 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. I understand that the data obtained by use of this authorization will be used by the Company to determine eligibility for insurance.

I agree that this authorization shall be valid for 24 months from the date of this application. 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 a photocopy of this authorization is as valid as the original. I have received a copy of this authorization. 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.

Advance Premium Paid: I have paid an advance premium with this application and I have been given the Life Insurance Conditional Receipt. In return I have read, understand, and agree to its terms.

Owner Taxpayer Identification Number Certification: As proposed owner of this contract, I certify under penalties of perjury: (1) The taxpayer identification number shown on this application is correct, (2) I am not subject to IRS backup withholding, and (3) I am a U.S. person (which includes a U.S. resident alien). If subject to backup withholding complete W-9. If not a U.S. person complete W-8. **The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.**

CLIENT COPY



Principal Life Insurance Company
Principal National Life Insurance Company
Members of Principal Financial Group®

P.O. Box 10431
 Des Moines, IA 50306-0431

Life Insurance
Conditional
Receipt

Only one company is the issuer and responsible for obligations of any given policy and is hereinafter referred to as "the Company".

Name of Proposed Insured(s)	Advance payment of: \$	Date of Application:
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(In this Receipt, "we", "us", "our", or "the Company" is Principal Life Insurance Company) is the Company which issues the policy, Principal Life Insurance Company or Principal National Life Insurance Company, respectively.

AUTHORITY:

This Receipt is not a "binder." No agent, broker, or licensed representative may accept risks, determine insurability or bind the Company in any way. No agent, broker, or licensed 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 agent, broker, or licensed representative has **NO AUTHORITY** to accept any premium or to issue this Receipt: if it is apparent that any **Condition Precedent** to coverage under this Receipt is not or cannot be satisfied. **This Conditional Receipt shall be ineffective if issued without authority. Only the Home Office, and not the agent, broker, or licensed representative, has authority to modify any provisions of this Receipt.**

TERMS AND CONDITIONS:

The Company will pay a death benefit to the beneficiary named in the Application if the proposed insured dies while this Conditional Receipt is in effect, subject to the terms and conditions set out below.

1. CONDITIONS PRECEDENT: All the following conditions must be fulfilled exactly. Otherwise there is **NO insurance under this Receipt and the Receipt is void:** (a) On the Start Date, the Proposed Insured must be living and insurable, as determined by our underwriters under our underwriting guidelines. If a condition affecting such insurability existed in fact on the Start Date, it shall be considered in the determination of insurability; and (b) The premium deposit must be at least one full month's premium for each policy applied for; and (c) This Receipt must be issued at the same time as the application; and (d) The premium deposit must be received in our Home Office and must be honored on first presentment for payment.

2. AMOUNT OF COVERAGE: The amount of insurance provided by this Receipt shall be that applied for on the Application, subject to all the **LIMITATIONS** set forth in this Receipt, and will be the lesser of: (a) The amount of all death benefits applied for in the Application; or (b) \$200,000.

This total death benefit limit applies to all insurance applied for under this and any current Applications to the Company and any other Conditional Receipts that may be in effect with us.

3. DATE COVERAGE BEGINS: If all of the **Conditions Precedent** set forth in this Receipt are fulfilled exactly, insurance under this Receipt takes 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.

4. DATE COVERAGE ENDS: Any insurance provided by this Receipt ends on the **Stop Date**, which is the **earliest** of: (a) 75th day after the Start Date; or (b) the date we mail the proposed owner a premium refund and a notice that no policy will be issued on the Application; or (c) when policy coverage becomes effective.

5. HEALTH AND INSURABILITY: This Receipt does not commit us to issue any policy. However, in determining whether to issue this policy and on what terms, we will consider no changes in a Proposed Insured's health or insurability occurring between the Start Date and the Stop Date. We have until policy coverage becomes effective to make this determination.

6. LIMITATIONS: (a) Our Liability: Except as limited by this Receipt, our liability is governed by the terms of the policy(ies) applied for; and (b) Suicide: No death benefit is payable under this Receipt if the Proposed Insured dies by suicide while sane or insane. In such case, our sole liability shall be to pay the premium we received to the named beneficiary(ies); and (c) Misrepresentation: No benefit is payable under this Receipt and this Receipt is void, if there is any incorrect, untrue, incomplete, or omitted statement of material fact in the Application. No knowledge of any fact on the part of any agent, broker, licensed representative, or other person shall be considered knowledge of the Company unless such fact is stated in the Application; and (d) Other: If any provision of this Receipt is unenforceable under state law, all other terms and conditions shall continue in full force and effect.

7. DEATH PROCEEDS: If an event giving rise to a claim occurs at any time before the Stop Date of this Receipt, coverage will be considered solely under this Receipt even if a policy is issued. If an event giving rise to a claim occurs at any time after the Stop Date of this Receipt but before policy coverage becomes effective, then the Company shall incur no liability under the Receipt or the Policy even if a policy is issued.

8. PREMIUMS: If a policy is issued from the Application bearing the same date listed on this Receipt and 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 into force but a benefit is paid under this Receipt, we will keep the premium deposit. If no policy is put into force and no benefit is paid under this Receipt, the premium deposit will be refunded. **ALL PREMIUM CHECKS MUST BE MADE PAYABLE TO THE COMPANY AS INDICATED ON PAGE ONE OF THE APPLICATION – DO NOT MAKE CHECK PAYABLE TO THE AGENT OR LEAVE THE CHECK PAYEE BLANK.**



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SPORT STATEMENT

Check type of sport and answer questions.

RACING – Check one type only on this form. If you have in the past or now engage in different types of racing, please fill out one form for each type.

<input type="checkbox"/> Automobile <input type="checkbox"/> Stock car <input type="checkbox"/> Championship <input type="checkbox"/> Drag <input type="checkbox"/> Sports car <input type="checkbox"/> Sprint <input type="checkbox"/> Go-Kart <input type="checkbox"/> Other _____ <input type="checkbox"/> Motorcycle <input type="checkbox"/> Hill climbing <input type="checkbox"/> Enduro <input type="checkbox"/> Drag <input type="checkbox"/> Flat track <input type="checkbox"/> Moto cross <input type="checkbox"/> Other _____ <input type="checkbox"/> Motor boat <input type="checkbox"/> Snowmobile	1. Number of races in last 12 months _____ One to two years ago _____ Lifetime _____ Plan to in the next 12 months _____ 2. Date of last race _____ 3. Make and type of vehicle _____ formula and / or engine displacement _____ 4. Top speed _____ Average speed _____ Usual distance of race _____ 5. Do you compete for cash prizes? <input type="checkbox"/> Yes <input type="checkbox"/> No 6. Cities / towns where you race _____ 7. Describe track layout and surface _____ 8. Vehicle class _____ 9. Organization(s) which sanctions your races _____ 10. Do you plan to do any other type of racing? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", give details _____ _____
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<input type="checkbox"/> Scuba <input type="checkbox"/> Skin diving	1. Number of dives in last 12 months _____ One to two years ago _____ Lifetime _____ Plan to in next 12 months _____ 2. Date of last dive _____ 3. How deep usually _____ Deepest dive _____ In last year how many times below 30 feet _____ 50 feet _____ 75 feet _____ 100 feet _____ 4. Location(s) <input type="checkbox"/> Ocean <input type="checkbox"/> Lake <input type="checkbox"/> River <input type="checkbox"/> Other _____ 5. National organization(s) you are certified with _____ 6. Describe equipment used _____ 7. Do you, or do you plan to dive for pay? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", give details _____
--	---

<input type="checkbox"/> Sky diving	1. Number of jumps in last 12 months _____ One to two years ago _____ Lifetime _____ Plan to in next 12 months _____ 2. Date of last jump _____ 3. Minimum height chute has opened _____ 4. Reserve chute used? <input type="checkbox"/> Yes <input type="checkbox"/> No _____ 5. National sky diving member? <input type="checkbox"/> Yes <input type="checkbox"/> No _____ 6. Do you, or do you plan to dive for pay? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", give details. _____
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<input type="checkbox"/> Hang kite gliding <input type="checkbox"/> Mountain climbing <input type="checkbox"/> Rodeo <input type="checkbox"/> Other	These sports require a special form from underwriting.
--	--

I represent that all statements on this form are true and complete to the best of my knowledge and belief. They are a part of my insurance application.

 Signature of Proposed Insured Date Signature of Licensed Agent/Broker/Representative



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Application Supplement

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AVIATION STATEMENT

<p>1. List hours flown as pilot or crew member by type of flying</p> <table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width:30%;">Type of flying</th> <th style="width:15%;">1 to 2 yrs. ago</th> <th style="width:15%;">Last 12 months</th> <th style="width:15%;">Estimate next 12 months</th> </tr> </thead> <tbody> <tr><td>Student</td><td></td><td></td><td></td></tr> <tr><td>Private</td><td></td><td></td><td></td></tr> <tr><td>Scheduled passenger airline</td><td></td><td></td><td></td></tr> <tr><td>Full-time company</td><td></td><td></td><td></td></tr> <tr><td>Non-scheduled or charter</td><td></td><td></td><td></td></tr> <tr><td>Crop dusting or aerial spraying</td><td></td><td></td><td></td></tr> <tr><td>Student instruction</td><td></td><td></td><td></td></tr> <tr><td>Military</td><td></td><td></td><td></td></tr> <tr><td>Other (describe in #7)</td><td></td><td></td><td></td></tr> </tbody> </table> <p>2. Total number of hours flown as pilot _____</p> <p>3. Date of last flight as pilot _____</p> <p>4. Type of licenses <input type="checkbox"/> Student <input type="checkbox"/> Private <input type="checkbox"/> Commercial <input type="checkbox"/> ATP <input type="checkbox"/> Other _____</p>	Type of flying	1 to 2 yrs. ago	Last 12 months	Estimate next 12 months	Student				Private				Scheduled passenger airline				Full-time company				Non-scheduled or charter				Crop dusting or aerial spraying				Student instruction				Military				Other (describe in #7)				<p>5. Do you have an Instrument Flight Rating (IFR)? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <hr/> <p>6. Types of aircraft</p> <p>A. Civilian</p> <p><input type="checkbox"/> Prop or jet <input type="checkbox"/> Glider</p> <p><input type="checkbox"/> Helicopter <input type="checkbox"/> Experimental</p> <p><input type="checkbox"/> Hot air balloon <input type="checkbox"/> Other _____</p> <p>B. Military</p> <p><input type="checkbox"/> Fighter <input type="checkbox"/> Helicopter</p> <p><input type="checkbox"/> Bomber <input type="checkbox"/> Reconnaissance</p> <p><input type="checkbox"/> Transport or cargo <input type="checkbox"/> Experimental</p> <p><input type="checkbox"/> Other _____</p> <hr/> <p>7. Describe any unusual aviation activity</p> <p>_____</p> <p>_____</p> <p>_____</p> <hr/> <p>8. If not standard I request <input type="checkbox"/> an extra premium, or <input type="checkbox"/> an aviation exclusion (if available)</p>
Type of flying	1 to 2 yrs. ago	Last 12 months	Estimate next 12 months																																						
Student																																									
Private																																									
Scheduled passenger airline																																									
Full-time company																																									
Non-scheduled or charter																																									
Crop dusting or aerial spraying																																									
Student instruction																																									
Military																																									
Other (describe in #7)																																									

MILITARY STATEMENT

<p>1. Branch</p> <p><input type="checkbox"/> Air Force <input type="checkbox"/> Navy <input type="checkbox"/> Coast Guard <input type="checkbox"/> Marines <input type="checkbox"/> Army-list arm (Inf., Engr., etc.) _____</p> <hr/> <p>2. Pay grade _____</p> <hr/> <p>3. Job title _____</p> <hr/> <p>4. Type of duty</p> <p><input type="checkbox"/> Active <input type="checkbox"/> National Guard <input type="checkbox"/> Ready Reserve <input type="checkbox"/> Standby Reserve <input type="checkbox"/> ROTC – list commission date _____</p>	<p>5. Does your job include</p> <p>a. Demolition duties? <input type="checkbox"/> Yes <input type="checkbox"/> No b. Submarine duty? <input type="checkbox"/> Yes <input type="checkbox"/> No c. Special forces? <input type="checkbox"/> Yes <input type="checkbox"/> No d. Carrier duty? <input type="checkbox"/> Yes <input type="checkbox"/> No e. MAC or FLOG? <input type="checkbox"/> Yes <input type="checkbox"/> No f. Other duties? (describe) _____</p> <hr/> <p>6. Is overseas duty in next 12 months?</p> <p>a. Likely? <input type="checkbox"/> Yes <input type="checkbox"/> No b. Certain? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If "yes", give date _____ and place _____</p> <hr/> <p>7. Date present tour ends _____</p> <hr/> <p>8. Do you plan to re-enlist? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
--	--

I represent that all statements on this form are true and complete to the best of my knowledge and belief. They are a part of my insurance application.

 Signature of Proposed Insured Date Signature of Licensed Agent/Broker/Representative



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P.O. Box 10431
 Des Moines, IA 50306-0431

**Application
 Supplement
 Life Insurance**

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CONFIDENTIAL FINANCIAL STATEMENT

1. Name of Proposed Insured _____ Amount of Insurance Requested _____

2. Business Insurance: Answer questions 2, 4, 5, 6

- Key Person Buy/sell Stock Redemption Deferred Compensation
 Required by creditor (debt protection) Split Dollar Other _____

3. Personal Insurance: Answer questions 3, 4, 6, 7

- Final Expenses Family Income Replacement Estate Liquidity
 Mortgage Retirement Plan Charitable Giving
 Other _____

4. Explain in detail the need for the insurance requested _____

Is amount applied for based on recommendation from Sales Services? Yes No

5. Is proposed insured owner in business? _____ % of Ownership? _____

Are other partners, corporate officers or keypersons insured or being insured with similar amounts? Yes No
 If "No," why not? _____

For other owners, list:

Name	Title	% Ownership	Amount of Business Insurance In Force
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Net worth of business: Book value \$ _____ Fair Market Value \$ _____

How was the value of the business determined? _____

Gross Annual Sales \$ _____ Net Annual Income of Business (before taxes) \$ _____

Is insurance required by creditor? Yes No Amount of loan \$ _____

Earned Income:	Last Year	Previous Year
Salary	\$ _____	\$ _____
Bonus	_____	_____
Other	_____	_____
Unearned Income (interest, rentals, etc.)	_____	_____
Total	\$ _____	\$ _____

7. Current personal financial status
 Assets at current market value \$ _____
 Liabilities \$ _____
NET WORTH \$ _____

I represent that these statements are true and complete to the best of my knowledge and belief. They are a part of my insurance application.

 Signature of Proposed Insured Date Signature of Licensed Agent/Broker/Representative



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 Simplified Issue
 Life Insurance
 Application**

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Note: Complete Part A for Guaranteed Issue. Complete Part A and B for Simplified Issue.

PART A

1. PERSONAL INFORMATION ABOUT THE PROPOSED INSURED

Name (First, Middle, Last)	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth / /
Primary Residence Street Address	Social Security Number - -	Birthplace (State, or Country if not U.S.)
City, State, Zip Code	Driver's License Number	State Issued
Home Phone Number ()	Occupation	
Work Phone Number ()	Workplace Zip Code	

2. BASIC COVERAGE APPLIED FOR

Product _____	Policy Planned Premium \$ _____
Face Amount (excluding riders) \$ _____	Premium Frequency: (choose one) <input type="checkbox"/> Annual <input type="checkbox"/> Semi Annual <input type="checkbox"/> Quarterly <input type="checkbox"/> Single Pay <input type="checkbox"/> EFT (complete EFT form + attach sample check)
Death Benefit Option if applicable: <input type="checkbox"/> Option 1: Level Face Amount <input type="checkbox"/> Option 2: Face + Accumulated/Policy Value <input type="checkbox"/> Option 3: Face + Premiums Paid Less Partial Surrenders	List Bill Number _____ <input type="checkbox"/> Annual <input type="checkbox"/> Semi Annual <input type="checkbox"/> Quarterly <input type="checkbox"/> Monthly Unscheduled Premium \$ _____

3. BENEFITS/RIDERS (Some riders are not available with all products)

<input type="checkbox"/> Accounting Benefit	<input type="checkbox"/> _____
<input type="checkbox"/> Alternate Cash Surrender Value	<input type="checkbox"/> _____
<input type="checkbox"/> Change of Insured	<input type="checkbox"/> _____
<input type="checkbox"/> Salary Increase – Amount \$ _____	<input type="checkbox"/> _____

4. BENEFICIARY INFORMATION

Primary Beneficiary	Relationship to Proposed Insured
_____	_____
Contingent Beneficiary	Relationship to Proposed Insured
_____	_____

Proposed Insured Name _____

5. OWNERSHIP INFORMATION (complete if different than the insured)

Owner Name (If trust, provide name of trust*)	Relationship to Proposed Insured
Primary Residence Street Address	Taxpayer Identification Number
City, State, Zip Code	Date of Birth (If trust, provide date of trust*)
Joint Owner Name	Relationship to Proposed Insured
Primary Residence Street Address	Taxpayer Identification Number
City, State, Zip Code	Date of Birth
Contingent Owner Name	Relationship to Proposed Insured

* Submit copy of trust with this application.

6. OTHER INSURANCE

(a) Is there other life insurance or annuities in force or applied for? Yes No
(If yes, list all other life insurance or annuities in force or currently being applied for, even if sold, assigned, or viaticated.)

Insured's Name	Company	Amount	Policy Number	Check if Pending	Year Issued	Primary Purpose
		\$		<input type="checkbox"/>		
		\$		<input type="checkbox"/>		
		\$		<input type="checkbox"/>		
		\$		<input type="checkbox"/>		

(b) If coverage is pending, will all pending coverage be accepted? Yes No
If no, explain. _____

7. REPLACEMENT

(a) Will the insurance applied for with this application replace or affect any of the Owner's other life or annuity contracts (including pending coverage provided with a binding receipt)? Yes No
If yes, list company name(s) and policy number(s) and provide necessary forms:

(b) Is this an Internal Revenue Code section 1035 exchange? Yes No

8. ACTIVELY AT WORK

(a) Are you actively at work full time (30 hours or more per week) at your usual place of business on the date this application is signed? Yes No
If no, please explain _____

(b) Have you missed 5 or more consecutive days in the past 90 days because of medical reasons such as illness or injury? Yes No
If yes, please explain _____

9. TOBACCO USE

Within the past 12 months, have you used cigarettes, cigars, pipe, chewing tobacco, snuff, nicotine gum/patch or other products containing nicotine? Yes No
If yes, provide details _____



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PART C – AGREEMENT/AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

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 the application, including statements by the Proposed Insured in any medical questionnaire that becomes a part of this application, shall be the basis of any insurance issued. I also understand that misrepresentations can mean denial of an otherwise valid claim and rescission of the policy during the contestable period.

I understand that the policy(ies) delivered to me may be from a different issuer than what was listed in the application. I understand and agree that my acceptance of the policy(ies) shall be considered an amendment to this application. Each policy has only one issuing company and that issuer is solely responsible for the obligations under that policy.

When Policy Coverage Becomes Effective: I understand and agree that if a policy is issued as applied for with a premium deposit paid, policy coverage will become effective as of issuance. The Company agrees to pay any proceeds pursuant to policy terms subject to the acceptance of the proposed owner.

I understand and agree that if a policy is issued as other than applied for or without a premium deposit (C.O.D.), then policy coverage is not effective and the Company shall incur no liability unless:

- 1) A policy issued on this application has been physically delivered to and accepted by the owner and the first premium paid; and
- 2) At the time of such delivery 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 Acknowledgement of Delivery form is signed by me and the Proposed Insured (if different than me) and dated at delivery.

If these conditions are met, the policy is deemed effective on the Policy Date stated in the policy data pages.

Limitation of Authority: I understand and agree that no agent, broker, licensed 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 agent, broker, licensed representative, telephone interviewer, medical examiner or other person shall be considered knowledge of the Company unless such fact is stated in the application.

If my employer is the owner and beneficiary on this application: I agree to allow my employer to purchase insurance on my life. I understand that my employer or trustee will have all present and future rights of ownership and will also be the beneficiary of the policy. There is no obligation, on my part, to pay the policy premiums. I acknowledge that as an employee, the employer or trustee has an insurable interest in my life. I understand and agree that my administrators, estate, heirs and assignees have no rights to the policy or any policy proceeds. I understand that the maximum face amount for which I could be insured at the time of issuance is generally not more than 30 times compensation, up to a maximum of \$30,000,000, subject to underwriting guidelines. I further authorize my employer or trustee to increase or decrease the amount of insurance on my life in the future without another consent from me and without further notice to me as long as I am employed by the employer. I consent to and authorize my employer, trustees, or its successors to continue to be the owner and beneficiary of this policy(s) indefinitely including after the end of my employment by the employer.

AUTHORIZATION

I authorize any insurance (or reinsuring) company, consumer reporting agency, governmental agency, insurance agent, broker, licensed representative, or any other organization, institution or person having personal information (including physical, mental, drug or alcohol use history) regarding me, the named proposed insured, to provide to the Company, its representatives or reinsurers, any such data. I authorize the Company or its representative to conduct a telephone interview in connection with my application for insurance.

I understand and agree to sign any authorization that is required to authorize any doctor, hospital, clinic, health care provider, laboratory, pharmacy benefit manager or any other institution having personal information (including physical, mental, drug or alcohol use history) regarding the named proposed insured to provide the Company, its representatives or reinsurers any such data. I understand that if I refuse to sign an authorization to release my complete medical record, the Company may not be able to process my application for life insurance coverage.

PART C – AGREEMENT/AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION (CONTINUED)

I authorize the Medical Information Bureau (MIB, Inc.) to furnish the above data to the Company, its representative or its reinsurers. I authorize the Company or its representative 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 agree that this authorization shall be valid for 24 months from the date of this application. 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 a photocopy of this authorization is as valid as the original. I have received a copy of this authorization. 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.

C.O.D. or Advance Premium Paid:

- This application is C.O.D. and I have not been given any Conditional Receipt with this application.
- I have paid \$ _____ as an advance premium with this application which is no less than one month's advance premium and I have been given the Life Insurance Conditional Receipt. In return I have read, understand, and agree to its terms.
- I have submitted an Absolute Assignment form with this application and I have been given the Life Insurance 1035 Conditional Receipt. In return I have read, understand, and agree to its terms.

Warning: It is a crime to provide false, misleading, or incomplete information to an insurance company for the purpose of defrauding the company or any other person. Penalties include imprisonment and/or fines and denial of insurance benefits.

OWNER TAXPAYER IDENTIFICATION NUMBER CERTIFICATION: As proposed owner of this contract, I certify under penalties of perjury: (1) The taxpayer identification number shown on this application is correct, (2) I am not subject to IRS backup withholding, and (3) I am a U.S. person (which includes a U.S. resident alien). If subject to backup withholding complete W-9. If not a U.S. person complete W-8. **The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.**

Signatures – Please read all of the above Agreements, Authorizations, and Certification before signing below.

Signature of Proposed Insured (If age 15 or over)		
X		
Signature of Parent (If Proposed Insured is under age 18 and Parent has not signed as Owner)		
X		
Signature of Owner(s), if other than Proposed Insured. If corporation, an officer other than the Proposed Insured must sign and include officer's title. If joint ownership or Trust, all joint owners/trustees must sign. If signing as a Trustee include 'Trustee' as title.		
X	Title	
X	Title	
X	Title	
Date	Signature of Licensed Agent/Broker/Representative	License Number
	X	
Cosignature by resident Licensed Agent/Broker/Representative, if applicable in your state	Date	License Number
X		



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CLIENT COPY

PART C – AGREEMENT/AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION (CONTINUED)

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**Medical
 Questionnaire**

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Print full name of Proposed Insured _____ Date of Birth (Month/Day/Year) _____

- | | Yes | No |
|---|--------------------------|--------------------------|
| 1. In the last ten years, have you had, been treated for or been diagnosed as having: | | |
| a. high blood pressure, heart attack, chest pain, heart murmur, irregular heart beat, stroke, anemia, or any other disease or disorder of the heart or blood vessels? | <input type="checkbox"/> | <input type="checkbox"/> |
| b. cancer or a tumor, cyst or growth? | <input type="checkbox"/> | <input type="checkbox"/> |
| c. asthma, bronchitis, emphysema, tuberculosis or any other disease or disorder of the lungs or respiratory system? | <input type="checkbox"/> | <input type="checkbox"/> |
| d. seizure, paralysis, headaches, multiple sclerosis or any other disease or disorder of the brain or nervous system? | <input type="checkbox"/> | <input type="checkbox"/> |
| e. chronic fatigue, stress, depression, anxiety or any other emotional or psychological disorder? | <input type="checkbox"/> | <input type="checkbox"/> |
| f. hepatitis, colitis, ulcer, cirrhosis, irritable bowel or any other disease or disorder of the liver, gallbladder, pancreas or digestive tract? | <input type="checkbox"/> | <input type="checkbox"/> |
| g. diabetes, borderline diabetes, sugar in the urine, thyroid disorder or any other disease or disorder of the glandular system? | <input type="checkbox"/> | <input type="checkbox"/> |
| h. kidney stones, nephritis, any blood or protein in the urine, sexually transmitted disease, prostate disorder, breast disorder or any other disease or disorder of the urinary or reproductive system? | <input type="checkbox"/> | <input type="checkbox"/> |
| i. back or neck pain, disc problems, spinal sprain or strain, sciatica, arthritis, carpal tunnel syndrome, fibromyalgia, or any other disease or disorder of the bones, joints, or muscles? | <input type="checkbox"/> | <input type="checkbox"/> |
| j. any disease or disorder of the eyes, ears, nose, throat or skin? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. (DI Only) Are you currently pregnant or have you had complications of pregnancy in the last ten years? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. In the last ten years, have you had, been treated for or been diagnosed as having HIV (Human Immunodeficiency Virus) infection, positive HIV (Human Immunodeficiency Virus) test or AIDS (Acquired Immunodeficiency Syndrome)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. In the last ten years: | | |
| a. have you had any medical tests, hospitalization, illness or injury not provided in response to a previous question? | <input type="checkbox"/> | <input type="checkbox"/> |
| b. have you consulted a doctor, chiropractor, psychiatrist, psychologist, counselor, therapist or other healthcare provider not provided in response to a previous question? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Are you taking or have you been advised to take any medication or treatment not provided in response to a previous question? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you lost more than 10 lbs. in the last year? | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, ___ lbs./kgs. Indicate reason. _____ | | |
| 7. a. Has either of your natural parents lived to at least age 60? | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Do any of your natural parents or siblings have a history of diabetes, cancer, stroke or heart disease? | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, provide details (i.e., relationship, type of disease, age diagnosed, current age or age at death) | | |
| 8. Have you ever had any life, health or disability insurance rated, rided or declined? (If yes, provide details).... | <input type="checkbox"/> | <input type="checkbox"/> |

DETAILS TO QUESTIONS 1-8

For "yes" answers to questions 1-6 include dates, details, diagnosis, types and results of treatment, healthcare provider's full name and address. (if additional space needed, attach a separate page that is completed, witnessed, signed, and dated)

Quest. #	

Medical Questionnaire, continued

9. Who is your Primary Physician? None

a. Name _____

Phone Number _____

Street _____

City _____

State _____

Zip _____

b. Date last seen, reason and details _____

I have read the statements and answers recorded above; they are to the best of my knowledge and belief true, complete and correctly recorded. I agree that they will become part of my application and any policy issued on it.

Signature of Proposed Insured _____

Date _____

Signature of Witness/Title _____

X

X

PHYSICAL MEASUREMENTS RECORDED BY EXAMINER

10. a. Height (in Shoes) feet _____ in. _____ ; or cm _____
 b. Weight (Clothed) pounds _____ ; or kg _____
 c. Did you weigh? Yes No Did you measure? Yes No
 d. Chest (Full Inspiration) in./cm. _____
 Chest (Forced Expiration) in./cm. _____
 Abdomen, at Umbilicus in./cm. _____

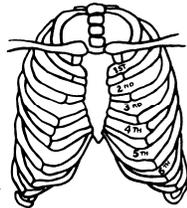
11. Blood Pressure in sitting position:

Systolic/ Diastolic	First Reading	Second Reading	Third Reading

12. Pulse:

Rate	At Rest
Irregularities per min.	

13. Heart: is there any:
 Enlargement Yes No Dyspnea Yes No
 Murmur(s) Yes No Edema Yes No
 (describe below)
 Location
 Constant Indicate:
 Inconstant
 Transmitted Apex by **X**
 Localized
 Systolic Murmur area by
 Diastolic Point of greatest
 Soft (Gr. 1-2) intensity by
 Mod. (Gr. 3-4) Transmission by
 Loud (Gr. 5-6)



14. Is there any abnormality of the following (circle applicable items and give details) on examination: Yes No
 (a) Eyes, ears, nose, mouth, pharynx?.....
 (If vision or hearing markedly impaired, indicate degree and correction.)
 (b) Skin (incl. scars); lymph nodes; varicose veins; peripheral arteries?
 (c) Nervous system (include reflexes, gait, paralysis)?
 (d) Respiratory system?.....
 (e) Abdomen (include scars)?.....
 (f) Genitourinary system (include prostate)?.....
 (g) Endocrine system (include thyroid and breasts)? ...
 (h) Musculoskeletal system (include spine, joints, amputations, deformities)?
 15. (a) Are there any hernias?.....
 (b) Any hemorrhoids?
 16. Are you aware of additional medical history?.....

Give details to "Yes" answers:

Name of agent soliciting application: _____

Examination made at: Examiner's Office Applicant's Home Other _____

Examiner (print name) _____ M.D./D.O./Para Med.

Exam Company Name _____

Exam Company Address _____

Signature of Examiner **X**

Send exam to Home Office only.



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Des Moines, IA 50306-0431

***Amendment to
Application***

Only one company is the issuer and responsible for obligations of any given policy and is hereinafter referred to as "the Company".

NOTE: This form MUST be returned to the Home Office fully signed and dated.

Policy No.:

Insured:

The application for the above Policy (or for its adjustment or reinstatement) is hereby amended as follows:

By signing below, I agree that any amendments to the Application listed above are part of the Application, and the Application and the amendments are to be taken as a whole. It is agreed that the above Policy is issued (or adjusted or reinstated, as applicable) on the basis of the statements in the Application and in this Amendment and Acceptance Form.

To be signed and dated by the person(s) indicated below:

Policyowner: _____ Insured: _____

Date: _____



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***Amendment and
Acceptance Form***

Only one company is the issuer and responsible for obligations of any given policy and is hereinafter referred to as "the Company".

CAUTION: The Policy listed below (or a requested adjustment or reinstatement thereof) will not become effective unless this form is signed as required below. This form (and any Rider Forms requiring the policyowner's signature) must be returned to the Home Office fully signed and dated, or the Policy returned for cancellation.

Policy No.:

Insured:

The above-identified Policy is issued (or adjusted or reinstated, as applicable) by the Company and accepted by the Policyowner subject to the following terms, provisions or amendments:

By signing below, I agree that any amendments to the Application listed above are part of the Application, and the Application and the amendments are to be taken as a whole. It is agreed that the above Policy is issued (or adjusted or reinstated, as applicable) on the basis of the statements in the Application and in this Amendment and Acceptance Form.

To be signed and dated by the person(s) indicated below:

Policyowner: _____ Insured: _____

Date: _____



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**Application for
Reinstatement
Of Policy**

<p>1. a. Proposed Insured _____</p> <p>b. Height _____ Weight _____ Occupation _____</p> <p>c. Do you use tobacco or nicotine products? <input type="checkbox"/> Never <input type="checkbox"/> Current <input type="checkbox"/> Past</p> <p>d. If current or past, indicate type/amount per day and date last used: <input type="checkbox"/> Cigarettes _____ <input type="checkbox"/> Pipe/Cigar _____ <input type="checkbox"/> Chew _____ <input type="checkbox"/> Patch/Gum _____</p> <p>Date last used _____</p> <p>e. Personal doctor _____ Address _____ Date last seen _____ Reason _____ Findings _____</p>	<p>2. Answer questions about spouse if covered by the above policy</p> <p>a. Spouse _____</p> <p>b. Height _____ Weight _____ Occupation _____</p> <p>c. Do you use tobacco or nicotine products? <input type="checkbox"/> Never <input type="checkbox"/> Current <input type="checkbox"/> Past</p> <p>d. If current or past, indicate type/amount per day and date last used: <input type="checkbox"/> Cigarettes _____ <input type="checkbox"/> Pipe/Cigar _____ <input type="checkbox"/> Chew _____ <input type="checkbox"/> Patch/Gum _____</p> <p>Date last used _____</p> <p>e. Personal doctor _____ Address _____ Date last seen _____ Reason _____ Findings _____</p>
--	--

Answer for all persons who were covered by the above policy (Insured, Spouse, Children, Payor)

Questions 3-6 relate to the past 5 years.

	Yes	No
3. Any checkup, diagnostic test, illness or injury?	<input type="checkbox"/>	<input type="checkbox"/>
4. Any hospitalization or surgery?	<input type="checkbox"/>	<input type="checkbox"/>
5. Any involvement in aviation (airplanes, ultra-lights), racing (sports car, motorcycle, boat, snowmobile), diving (scuba, skin, sky) or hang gliding?	<input type="checkbox"/>	<input type="checkbox"/>
6. Has any person had, been treated for or diagnosed as having any disease or disorder of the immune system, including being infected with the HIV (AIDS) virus?	<input type="checkbox"/>	<input type="checkbox"/>
7. Any person now under observation or treatment?	<input type="checkbox"/>	<input type="checkbox"/>

Explain "Yes" answers below. List person's name.

Include diagnosis, treatment, duration, results and name/address of doctor or medical facility.

Any person who knowingly and with intent to defraud any insurance company or other person submits a statement of claim or any application form 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. Such action may be considered felonies and subject to criminal and civil penalties, including imprisonment and fines.

I declare that all of the above statements on this form are true and complete to the best of my knowledge and are true and complete and were correctly recorded before I signed my name below. These statements are made to induce the Company to reinstate the policy. No reinstatement is effective unless and until:

- (1) the Company has approved this application, and
- (2) all requirements for reinstatement set forth in the policy have been satisfied.

If reinstatement is not approved, the Company will refund any remittance submitted with this application.

Dated at _____ (City) _____ (State) Date _____

Signature of Proposed Insured (if age 10 or over) _____

Signature of Spouse/Payor (if covered) _____ Signature of Owner (if other than Insured) _____ Signature of Producer (if completed by direct contact) _____



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**Notice of Insurance
Information Practices**

Only one company is the issuer and responsible for obligations of any given policy and is hereinafter referred to as "the Company".

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 condition, medical history, job, age, hobbies, and character. 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) accountant, (3) 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., (9) governmental agencies, and (9) consumer reporting agencies. 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 request to be interviewed if we request this report. Data collected and retained by a consumer reporting agency may be disclosed to other insurance companies who have proper authorization.

Our Use Of Information

We follow strict standards to safeguard your personal information. It will be seen only by employees and agents of the 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 be able to give us proper identification. You may be charged a fee for any copies of your data. You have the right to know what information we have on file about you. You have the right to know the specific information leading to an adverse underwriting decision and the source of that information. We reserve the right to disclose medical information only to a doctor, and we will request that you provide us with the name and address of your physician. Within 21 days from the date we receive your request, we will furnish you and/or your doctor the information that we have about you that you are entitled to receive. 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 to whom we may have given such incorrect data. We will also delete data from your file if we agree that 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.

MIB Pre-Notice

Information regarding your insurability will be treated as confidential. The Company or its reinsurers may, however, make a brief report thereon to the MIB, Inc, formerly known as Medical Information Bureau, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its Members. If you apply to another MIB Member company for Life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request will supply such company with the information in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill, Suite 411, Braintree, MA 02184-8734. The Company or its reinsurers, may also release information in its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.

AA 836N AR

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P.O. Box 10431
 Des Moines, IA 50306-0431

**Financial Underwriting
 Supplement for
 Life Insurance**

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1. Proposed Insured 1 (First, Middle, Last)	Proposed Insured 2 (if Survivorship)			
Name of Owner(s)	Amount of Insurance \$ _____			
2. Explain how the amount of coverage was determined.				
3. Purpose of Insurance (select all that apply): <input type="checkbox"/> Income Replacement <input type="checkbox"/> Final Expenses <input type="checkbox"/> Estate Liquidity <input type="checkbox"/> Debt Protection <input type="checkbox"/> Charitable Giving <input type="checkbox"/> Other: _____				
4. Income	Insured 1		Insured 2	
	Last Year	Prior Year	Last Year	Prior Year
Annual Salary	\$ _____	\$ _____	\$ _____	\$ _____
Dividends	\$ _____	\$ _____	\$ _____	\$ _____
Investment Income	\$ _____	\$ _____	\$ _____	\$ _____
Pension/Retirement Income	\$ _____	\$ _____	\$ _____	\$ _____
Social Security	\$ _____	\$ _____	\$ _____	\$ _____
Undistributed Profits	\$ _____	\$ _____	\$ _____	\$ _____
Other	\$ _____	\$ _____	\$ _____	\$ _____
Total	\$ _____	\$ _____	\$ _____	\$ _____
5. Net Worth Please provide a complete accounting of assets and liabilities. See additional instructions at the end of the form about providing third party verification using this form, or what other forms of third party verification are accepted. If other forms of verification are being provided, you may skip to Question 6.				
<u>Assets:</u> Cash (Checking/Savings Accounts) \$ _____ Notes Receivable \$ _____ Accounts Receivable \$ _____ Real Estate \$ _____ Investment Accounts \$ _____ Business Interest \$ _____ Personal Property (art, jewelry, etc) \$ _____ Life Insurance Cash Value \$ _____ Retirement Accounts \$ _____ Other Assets \$ _____ Total Assets: \$ _____			<u>Liabilities</u> Mortgages \$ _____ Loans \$ _____ Notes Payable \$ _____ Accounts Payable \$ _____ Business Debt \$ _____ Taxes \$ _____ Other Liabilities \$ _____ Total Liabilities: \$ _____ Net Worth: \$ _____	
6. Premium Funding a) What is the planned source of the funding for the policy(ies) currently applied for? <input type="checkbox"/> Income <input type="checkbox"/> Premium financing – provide detail in Section 8 <input type="checkbox"/> Prior settlement <input type="checkbox"/> Asset liquidation, list assets to be liquidated: _____ <input type="checkbox"/> Other, please list: _____				
b) Has any party, other than the Proposed Owner or Proposed Insured offered to provide any funding or payment in exchange for any right, title or other interest in any policy issued on the life of the Proposed Life Insured(s) as a result of this application? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide details: _____				
c) Will the Owner, now or in the future, be paying premiums funded by an individual and/or an entity other than the Proposed Life Insured(s), or the Proposed Life Insured's employer? <input type="checkbox"/> Yes <input type="checkbox"/> No				



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7. Settlement

- a) Will any policy issued on the life of the Proposed Insured(s) as a result of this application replace a policy(ies) which has been viaticated or settled? Yes No If Yes, complete 7b. For multiple policies, provide answers to questions 7b-h on a separate page with the Proposed Insureds' name, witnessed, signed and dated.
- b) Insurance Company: _____
- c) Date of Issue: _____
- d) Date Settled or Viaticated: _____
- e) Amount received for settlement or viatication: _____
- f) Reason for settlement or viatication: _____
- g) What is the name of the Life Settlement Company? _____
- h) Who received the settlement proceeds?
 Insured Policy Owner, list name: _____ Business, list name: _____

8. Premium Financing

If premium financing is being used, provide details of the premium finance arrangement below. Please provide a copy of the premium finance term sheet.

- a) What is the loan interest rate? _____ %
 Interest is paid: annually accrued
- b) In addition to repayment of principal and interest, are there other fees, charges or other consideration to be paid on maturity? Yes No If Yes, provide details: _____
- c) What is the duration of the loan? _____
- d) Who is the lender? _____
- e) What collateral is required to secure the loan? Amount: \$ _____
 Type: _____
- f) When will the loan be repaid? _____
- g) How will the loan be repaid? _____

9. Life Expectancy

Will any entity other than a life insurance company be medically evaluating the Proposed Insured(s) to determine life expectancy? Yes No

Optional Third Party Verification

Third party verification must be provided by a disinterested person to the life insurance transaction. Acceptable forms of third party verification include an audited financial statement, current brokerage account statements, the most recent filed tax returns or loan documents.



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Warning: It is a crime to provide false, misleading, or incomplete information to an insurance company for the purpose of defrauding the company or any other person. Penalties include imprisonment and/or fines and denial of insurance benefits.

Signatures – I represent that these statements are true and complete to the best of my knowledge and belief. They will become a part of my insurance application.		
Signature of Proposed Insured 1 X	Signature of Proposed Insured 2 X	
Signature of Owner(s) , if other than Proposed Insured. If corporation, an officer other than the Proposed Insured must sign and include officer's title. If joint ownership or Trust, all joint owners/trustees must sign. If signing as a Trustee include 'Trustee' as title.		
Owner X	Title	
Owner X	Title	
Date	Signature of Licensed Agent/Broker/Representative X	License Number
Co-signature by resident Licensed Agent/Broker/Representative, if applicable in your state X	Date	License Number
Optional Third Party Verification Third party verification of Proposed Insured's financial information may be provided by completion of the signature block below. Third party verification must be provided by a disinterested person to the life insurance transaction. In lieu of the signed form other acceptable forms of third party verification include an audited financial statement, current brokerage account statements, the most recent filed tax returns or loan documents.		
Signature of Accountant/Attorney/Financial Advisor X		Date
Accountant/Attorney/Financial Advisor Name (Printed)	Length of time known Proposed Insured(s)	

<i>SERFF Tracking Number:</i>	<i>PRLD-125840447</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Principal National Life Insurance Company</i>	<i>State Tracking Number:</i>	<i>40642</i>
<i>Company Tracking Number:</i>	<i>AA1800N-L-PNL</i>		
<i>TOI:</i>	<i>L08 Life - Other</i>	<i>Sub-TOI:</i>	<i>L08.000 Life - Other</i>
<i>Product Name:</i>	<i>2009 Apps/Life</i>		
<i>Project Name/Number:</i>	<i>2009 Apps/Life/AA1800N</i>		

Rate Information

Rate data does NOT apply to filing.

SERFF Tracking Number: PRLD-125840447 State: Arkansas
Filing Company: Principal National Life Insurance Company State Tracking Number: 40642
Company Tracking Number: AA1800N-L-PNL
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
Product Name: 2009 Apps/Life
Project Name/Number: 2009 Apps/Life/AA1800N

Supporting Document Schedules

Review Status:

Satisfied -Name: Certification/Notice 10/01/2008

Comments:

We have reviewed our procedures and assure you that we are in compliance with and provide the notice required by Arkansas Code Ann. 23-79-138.

We have reviewed our issue procedures and assure you that we are in compliance with and provide the Life and Health guaranty notice required by Regulation 49.

We certify that the forms in the above numbered submission meet the provision of Rule and Regulation 19 regarding unfair sex discrimination in the sale of insurance, as well as all applicable requirements of the Department.

Review Status:

Satisfied -Name: List of submitted forms 10/22/2008

Comments:

Attached is a list of submitted forms.

Attachment:

AR-Application forms being filed.pdf

ARKANSAS

FORM #	FORM NAME	REPLACES
AA 1800 N	Insurance Application	AA 1800
AA 1900 N AR	Life Insurance Application	AA 1900 AR-1
AA 2000 N	Life Insurance Application	AA 2000-2
AA 3328 N	Life Insurance Conversion/Purchase Option/Policy Split App	AA 3328-1
AA 3329 N	Life Insurance Adjustment Application	AA 3329-1
AA 3406 N	Application for Multi-Life Guaranteed Issue Life Insurance	AA 3406
AA 3407 N	Adjustment Application for Multi-Life Life Insurance Policy(s)	AA 3407
AA 3432 N	Life Insurance Conditional Receipt	AA 3432
AA 3433 N	Life Insurance 1035 Conditional Receipt	AA 3433
AA 3443 N AR	Supplemental Statement	AA 3443 AR
AA 3447 N	Life Ins Adjustment Conditional Receipt	AA 3447
AA 3450 N	Worksite Term Life Insurance Application	AA 3450
AA 372 N	Application Supplement	AA 372
AA 631 N	Application Supplement - Life Insurance	AA 631
AA 648 N	Guaranteed/Simplified Issue Life Insurance App	AA 648-1
AA 672 N	Medical Questionnaire	AA 672-1
AA 973 N	Amendment to Application	AA 973
AA 974 N	Amendment and Acceptance Form	AA 974
AA 836 N AR	Application for Reinstatement Of Policy	AA 836
AA 3448 N	Financial Underwriting Supplement	AA 3448