

**State:** Arkansas **Filing Company:** Principal Life Insurance Company  
**TOI/Sub-TOI:** H11G Group Health - Disability Income/H11G.003 Long Term  
**Product Name:** Single Case Filing - Baptist Health (LTD)  
**Project Name/Number:** Baptist Health - Benefit duration period/S-2012-517

## Filing at a Glance

Company: Principal Life Insurance Company  
Product Name: Single Case Filing - Baptist Health (LTD)  
State: Arkansas  
TOI: H11G Group Health - Disability Income  
Sub-TOI: H11G.003 Long Term  
Filing Type: Form  
Date Submitted: 11/30/2012  
SERFF Tr Num: PRLF-128789957  
SERFF Status: Closed-Approved-Closed  
State Tr Num:  
State Status: Approved-Closed  
Co Tr Num: S-2012-517  
Implementation: On Approval  
Date Requested:  
Author(s): Bonnie Blue, Mark Curtis, Ann McCoy  
Reviewer(s): Rosalind Minor (primary)  
Disposition Date: 12/03/2012  
Disposition Status: Approved-Closed  
Implementation Date:

State Filing Description:

**State:** Arkansas **Filing Company:** Principal Life Insurance Company  
**TOI/Sub-TOI:** H11G Group Health - Disability Income/H11G.003 Long Term  
**Product Name:** Single Case Filing - Baptist Health (LTD)  
**Project Name/Number:** Baptist Health - Benefit duration period/S-2012-517

## General Information

Project Name: Baptist Health - Benefit duration period Status of Filing in Domicile: Not Filed  
Project Number: S-2012-517 Date Approved in Domicile:  
Requested Filing Mode: Review & Approval Domicile Status Comments:  
Explanation for Combination/Other: Market Type: Group  
Submission Type: New Submission Group Market Size: Large  
Group Market Type: Employer Overall Rate Impact:  
Filing Status Changed: 12/03/2012 Deemer Date:  
State Status Changed: 12/03/2012 Submitted By: Bonnie Blue  
Created By: Bonnie Blue  
Corresponding Filing Tracking Number:

### Filing Description:

Group Long Term Disability Insurance  
- Policy Forms: GC 3002 BHS, GC 3042 BHS  
- Booklet-Certificate forms: GH 802 BHS, GH 819 BHS

Enclosed for your review and approval are copies of the forms listed above which are being submitted on a single case basis. These policy pages and the booklet-certificates are based on the Group Long Term Disability Insurance forms approved by your Department on March 14, 2002, with subsequent revisions and additions also submitted and approved. If approved, the enclosed policy and booklet-certificate pages will be used for this one case only.

To the best of our knowledge, no part of this filing contains any unusual or possible controversial items from normal company or industry standards.

This large Group Policyholder has requested revisions to our previously filed and approved general use forms to revise the benefit duration period for long term disability – our previously approved product filing did not have these particular time periods included for the benefit duration period. The changes from our previously filed and approved general use forms have been italicized in red font for your ease in reviewing.

The required certification forms are enclosed.

If you have any questions on any of the attached materials, please feel free to contact me by fax, e-mail or at the number shown in the Contact Information tab.

## Company and Contact

### Filing Contact Information

Bonnie Blue, Compliance Advisor, Group blue.bonnie@principal.com  
Compliance  
711 High St. 800-986-3343 [Phone] 70657 [Ext]  
K-005-E90 515-246-4906 [FAX]  
Des Moines, IA 50392-0002

**State:** Arkansas **Filing Company:** Principal Life Insurance Company  
**TOI/Sub-TOI:** H11G Group Health - Disability Income/H11G.003 Long Term  
**Product Name:** Single Case Filing - Baptist Health (LTD)  
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**Filing Company Information**

Principal Life Insurance Company	CoCode: 61271	State of Domicile: Iowa
711 High Street	Group Code: 332	Company Type: Life & Health
Des Moines, IA 50392-0002	Group Name:	State ID Number:
(800) 986-3343 ext. [Phone]	FEIN Number: 42-0127290	

**Filing Fees**

Fee Required? Yes  
 Fee Amount: \$200.00  
 Retaliatory? No  
 Fee Explanation: 4 forms x \$50 each = \$200  
 Per Company: No

Company	Amount	Date Processed	Transaction #
Principal Life Insurance Company	\$200.00	11/30/2012	65307161

SERFF Tracking #:

PRLF-128789957

State Tracking #:

Company Tracking #:

S-2012-517

State:

Arkansas

Filing Company:

Principal Life Insurance Company

TOI/Sub-TOI:

H11G Group Health - Disability Income/H11G.003 Long Term

Product Name:

Single Case Filing - Baptist Health (LTD)

Project Name/Number:

Baptist Health - Benefit duration period/S-2012-517

## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	12/03/2012	12/03/2012

**State:** Arkansas  
**TOI/Sub-TOI:** H11G Group Health - Disability Income/H11G.003 Long Term  
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**Filing Company:** Principal Life Insurance Company

## Disposition

Disposition Date: 12/03/2012

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	No
Supporting Document	Application	Approved-Closed	No
Form	PART IA - Long Term Disability Insurance Summary	Approved-Closed	No
Form	PART IV - BENEFITS, Section M, Benefit Payment Period and Recurring Disability	Approved-Closed	No
Form	Long Term Disability Insurance Summary	Approved-Closed	No
Form	Description of Benefits - Benefit Payment Period and Recurring Disability	Approved-Closed	No

**State:** Arkansas  
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**Filing Company:** Principal Life Insurance Company

## Form Schedule

Lead Form Number: GC 3002 BHS								
Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments
1	Approved-Closed 12/03/2012	PART IA - Long Term Disability Insurance Summary	GC 3002 BHS	POLA	Initial			GC 3002 BHS.pdf
2	Approved-Closed 12/03/2012	PART IV - BENEFITS, Section M, Benefit Payment Period and Recurring Disability	GC 3042 BHS	POLA	Initial			GC 3042 BHS.pdf
3	Approved-Closed 12/03/2012	Long Term Disability Insurance Summary	GH 802 BHS	CERA	Initial			GH 802 BHS.pdf
4	Approved-Closed 12/03/2012	Description of Benefits - Benefit Payment Period and Recurring Disability	GH 819 BHS	CERA	Initial			GH 819 BHS.pdf

### Form Type Legend:

<b>ADV</b>	Advertising	<b>AEF</b>	Application/Enrollment Form
<b>CER</b>	Certificate	<b>CERA</b>	Certificate Amendment, Insert Page, Endorsement or Rider
<b>DDP</b>	Data/Declaration Pages	<b>FND</b>	Funding Agreement (Annuity, Individual and Group)
<b>MTX</b>	Matrix	<b>NOC</b>	Notice of Coverage
<b>OTH</b>	Other	<b>OUT</b>	Outline of Coverage
<b>PJK</b>	Policy Jacket	<b>POL</b>	Policy/Contract/Fraternal Certificate
<b>POLA</b>	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	<b>SCH</b>	Schedule Pages

**PART IA - LONG TERM DISABILITY INSURANCE SUMMARY**

Minimum Hours Requirement	Employees must be working at least 40 hours or more per pay period for part-time employees and at least 70 hours per pay period for full-time employees	
Member Contribution	<p>Full-time or Class 10: Members are not required to pay the premium for their insurance under this Group Policy.</p> <p>Class 3: Members may be required to pay a portion of the premium for their insurance under this Group Policy.</p> <p>Part-time or Class 9: Members are required to pay the entire premium for their insurance under this Group Policy.</p>	
Elimination Period	180 days	
Own Occupation Period	<p>For Classes 1 &amp; 5: two year(s)</p> <p>For Classes 2, 3, 4, 6, 7, 8, 9 &amp; 10: To Age 65</p>	
Primary Monthly Benefit	60% of the Member's Predisability Earnings.	
Maximum Monthly Benefit	<p>For Classes 1, 2, 4, 5, 6, 8, &amp; 10: \$10,000</p> <p>For Classes 3,7, &amp; 9: \$15,000</p>	
Minimum Monthly Benefit	\$100	
Maximum Benefit Payment Period	Member's Age on The Date Disability <u>Begins</u>	Months of the Benefit Payment <u>Period</u>
	Before age 62	<i>to age 67</i>
	62	<i>60 months</i>
	63	<i>48 months</i>
	64	<i>42 months</i>
	65	<i>36 months</i>
	66	<i>30 months</i>
	67	<i>24 months</i>
	68	<i>18 months</i>
	69 and over	12 months

<b>Rehabilitation Services and Benefits</b>	
Rehabilitation Services	Included
Predisability Intervention Services	Included
Rehabilitation Incentive Benefit	10%
Return to Work Child Care Benefit	\$350
Reasonable Accommodation Benefit	\$2,000
<b>Other Coverage Features</b>	
Work Incentive Benefit	12 months
Survivor Benefit	three times Primary Monthly Benefit
<b>NOTE:</b>	
No premiums are required during a Long Term Disability Benefit Payment Period.	
Benefits may be reduced by other sources of income and disability earnings.	
Some disabilities may not be covered or may be limited under this insurance.	

This summary provides only highlights of this Group Policy. The entire Group Policy determines all rights, benefits, exclusions and limitations of the insurance described above.

**Section M - Benefit Payment Period and Recurring Disability**

**Article 1 - Benefit Payment Period**

Benefits are payable:

- a. if Disability begins before age 62, *until the date the Member attains age 67*; or
- b. if Disability begins at or after age 62, until the date of completion of the number of months shown below after the Benefit Payment Period begins.

<u>Member's Age on the Date Disability Begins</u>	<u>Months of the Benefit Payment Period (Beginning with the date the Benefit Payment Period begins)</u>
62	<i>60</i>
63	<i>48</i>
64	<i>42</i>
65	<i>36</i>
66	<i>30</i>
67	<i>24</i>
68	<i>18</i>
69 and over	12

However, in no event, will benefits continue beyond:

- a. the date of the Member's death; or
- b. the date Disability ends, unless a Recurring Disability exists as explained in this section; or
- c. the date the Member fails to provide any required proof of Disability; or
- d. the date the Member fails to submit to any required medical examination or evaluation as provided in this PART IV, Section Q, Article 13; or
- e. the date the Member fails to report any required Current Earnings information; or
- f. the date the Member fails to report income from Other Income Sources; or
- g. the date ten days after receipt of notice from The Principal if the Member fails to pursue Social Security Benefits or benefits under a Workers' Compensation Act or similar law as outlined in this PART IV, Section Q, Article(s) 8 and 9; or

**PART IV - BENEFITS**

- h. if Disability results from a Mental Health Condition or a Special Condition, the date 12 months after the Benefit Payment Period begins; or
- i. the date the Member ceases to be under the Regular and Appropriate Care of a Physician; or
- j. the date the Member refuses to participate in or does not comply with a Rehabilitation Plan.

## **Article 2 - Recurring Disability**

A Recurring Disability will exist under this Group Policy if:

after completing an Elimination Period and during a Benefit Payment Period, a Member ceases to be Disabled; and

- a. the Member then returns to Active Work; and
- b. while insured under this Group Policy, but before completing six continuous months of Active Work, the Member is again Disabled; and
- c. the current Disability and the Disability for which the Elimination Period was completed result from the same or a related cause.

A Recurring Disability will be treated as if the initial Disability had not ended, except that no benefits will be payable for the time between Disabilities. The Member will not be required to complete a new Elimination Period. Benefits will be payable from the first day of each Recurring Disability, but only for the remainder, if any, of the Benefit Payment Period established for the initial Disability. The effective date of any salary increase received during return to Active Work as stated in PART III, Section B, Article 6 which would otherwise be effective, will not apply to any benefit payable under this Recurring Disability provision.

## **PART IV - BENEFITS**

## LONG TERM DISABILITY INSURANCE SUMMARY

Minimum Hours Requirement	Employees must be working at least 40 hours or more per pay period for part-time employees and at least 70 hours per pay period for full-time employees	
Who Pays for Coverage	<p>Full-time or Class 10: You are not required to pay the premium for insurance under the Group Policy.</p> <p>Class 3: You may be required to pay a portion of the premium for insurance under the Group Policy.</p> <p>Part-time or Class 9: You are required to pay the entire premium for insurance under the Group Policy.</p>	
Elimination Period	180 days	
Own Occupation Period	<p>For Classes 1 &amp; 5: two year(s)</p> <p>For Classes 2, 3, 4, 6, 7, 8, 9 &amp; 10: to Age 65</p>	
Primary Monthly Benefit	60% of your Predisability Earnings.	
Maximum Monthly Benefit	<p>For Classes 1, 2, 4, 5, 6, 8, &amp; 10: \$10,000</p> <p>For Classes 3,7 &amp; 9: \$15,000</p>	
Minimum Monthly Benefit	\$100	
Maximum Benefit Payment Period	Member's Age on The Date Disability <u>Begins</u>	Months of the Benefit Payment <u>Period</u>
	Before age 62	<i>To Age 67</i>
	62	<i>60 months</i>
	63	<i>48 months</i>
	64	<i>42 months</i>
	65	<i>36 months</i>
	66	<i>30 months</i>
	67	<i>24 months</i>
	68	<i>18 months</i>
	69 and over	12 months

<b>Rehabilitation Services and Benefits</b>	
Rehabilitation Services	Included
Predisability Intervention Services	Included
Rehabilitation Incentive Benefit	10%
Return to Work Child Care Benefit	\$350
Reasonable Accommodation Benefit	\$2,000
<b>Other Coverage Features</b>	
Work Incentive Benefit	12 months
Survivor Benefit	three times Primary Monthly Benefit
<b>NOTE:</b>	
No premiums are required during a Long Term Disability Benefit Payment Period.	
Benefits may be reduced by other sources of income and disability earnings.	
Some disabilities may not be covered or may be limited under this insurance.	

This summary provides only highlights of the Group Policy. The entire Group Policy determines all rights, benefits, exclusions and limitations of the insurance describe

## DESCRIPTION OF BENEFITS

### Benefit Payment Period and Recurring Disability

#### Benefit Payment Period

Benefits are payable:

- a. if your Disability begins before age 62, *until the date you attain age 67*; or
- b. if your Disability begins on or after age 62, until the later of completion of the number of months shown below after the Benefit Payment Period begins:

<u>Your Age on the Date Disability Begins</u>	<u>Months of the Benefit Payment Period (Beginning with the date the Benefit Payment Period begins)</u>
62	<i>60</i>
63	<i>48</i>
64	<i>42</i>
65	<i>36</i>
66	<i>30</i>
67	<i>24</i>
68	<i>18</i>
69 and over	12

However, in no event, will benefits continue beyond:

- a. the date of your death; or
- b. the date your Disability ends, unless a Recurring Disability exists as explained in this booklet; or
- c. the date you fail to provide any required proof of Disability; or
- d. the date you fail to submit to any required medical examination or evaluation; or
- e. the date you fail to report any required Current Earnings information; or
- f. the date you fail to report income from Other Income Sources; or
- g. the date ten days after receipt of notice from Us if you fail to pursue Social Security Benefits or benefits under a Workers' Compensation Act or similar law as described in this booklet; or

- h. if Disability results from a Mental Health Condition or a Special Condition, the date 12 months after the Benefit Payment Period begins; or
- i. the date you cease to be under the Regular and Appropriate Care of a Physician; or
- j. the date you refuse to participate in or do not comply with a Rehabilitation Plan.

### **Recurring Disability**

A Recurring Disability will exist under the Group Policy if:

- a. after you have completed an Elimination Period and during a Benefit Payment Period, you cease to be Disabled; and
- b. you then return to Active Work; and
- c. while insured under the Group Policy but before completing six continuous months of Active Work, you are again Disabled; and
- d. your current Disability and the Disability for which you completed the Elimination Period result from the same or a related cause.

A Recurring Disability will be treated as if the initial Disability had not ended, except that no benefits will be payable for the time between Disabilities. You will not be required to complete a new Elimination Period. Benefits will be payable from the first day of each Recurring Disability, but only for the remainder, if any, of the Benefit Payment Period established for the initial Disability. The effective date of any salary increase received during your return to Active Work as stated in this booklet on GH 805 which would otherwise be effective, will not apply to any benefit payable under this Recurring Disability provision.

SERFF Tracking #:

PRLF-128789957

State Tracking #:

Company Tracking #:

S-2012-517

State: Arkansas

Filing Company: Principal Life Insurance Company

TOI/Sub-TOI: H11G Group Health - Disability Income/H11G.003 Long Term

Product Name: Single Case Filing - Baptist Health (LTD)

Project Name/Number: Baptist Health - Benefit duration period/S-2012-517

## Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification	Approved-Closed	12/03/2012
Comments:			
Attachment(s):			
Readability Cert.pdf			

		Item Status:	Status Date:
Satisfied - Item:	Application	Approved-Closed	12/03/2012
Comments:	Included in filing PRLF-125859759 and previously approved on 10/27/2008		
Attachment(s):			
GP 47796-3.pdf			

**STATE OF ARKANSAS  
INSURANCE DEPARTMENT**

**CERTIFICATION OF READABILITY**

I, Kimberly Douglas, an Officer of Principal Life Insurance Company hereby certify that the attached form(s) has (have) achieved a Flesch Reading Ease Score of:

Form No.	Form Name	Flesch Score
GC 3002 BHS	Group Long Term Disability Insurance Policy Form - PART IA – Long Term Disability Insurance Summary	46.1
GC 3042 BHS	Group Long Term Disability Insurance Policy Form - PART IV – Benefits, Section M – Benefit Payment Period and Recurring Disability	64.5
GH 802 BHS	Booklet-Certificate Form – Long Term Disability Insurance Summary	48.5
GH 819 BHS	Booklet-Certificate Form – Description of Benefits - Benefit Payment Period and Recurring Disability	62.5

and complies with the requirements of Ark. Stat. Ann. Sections 66-3251 through 66-3258, cited as the Life and Disability Insurance Policy Language Simplification Act.

PRINCIPAL LIFE INSURANCE COMPANY



\_\_\_\_\_  
Kimberly Douglas, Director  
Group Life and Health Compliance

November 30, 2012

\_\_\_\_\_  
Date

12/1999





Mailing Address: Des Moines, IA 50392-0002

Principal Life Insurance Company Health Statement for Self Administered Plans – AR

Account Number / Unit Number

Employer to Complete This Section: After completing make a copy of Page 1 for your records before you give the form to your employee.

Employer name

Direct all employer's correspondence regarding this statement to: Name

Address (street)

City State ZIP code Phone

Employee's name Social security number Date of hire Annual salary \$

Effective date as per contractual provisions
[ ] first of month following approval [ ] date of approval [ ] other
[ ] open enrollment – effective date

This statement is: (place a "(√)" in each box that applies)
[ ] for employee [ ] add new coverages [ ] increase in current coverages
[ ] for dependent(s)
[ ] timely (made within eligibility period for employees). [ ] over non medical maximum

Why is Health Statement being submitted?

[ ] late

Please check the coverages (and indicate the new amount or increase in amount) being applied for at this time. See your benefit plan/contract for proof of good health rules that apply to your plan.

Table with columns: Current Benefit Amount, Total Requested Benefit Amount. Rows include: basic life, supplemental life, dependent life, voluntary term life (employee), voluntary term life (spouse), voluntary term life (child), short term disability (benefit), long term disability (benefit). Includes checkboxes for disability qualification period (1 month, 3 months, 6 months, other).

**Employee to Complete This Section**

**120-0**

Your name (last, first, middle initial) \_\_\_\_\_ Home phone number \_\_\_\_\_

Home address (street) \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP code \_\_\_\_\_

Date of birth \_\_\_\_\_ Are you married?  male  female  yes  no Date of marriage \_\_\_\_\_

Name of spouse \_\_\_\_\_ Spouse's social security number \_\_\_\_\_ Spouse's date of birth \_\_\_\_\_

This statement is for:  myself  my spouse  my children

Name of each dependent child applying for coverage (last, first, middle initial)	Social security number	Sex	Date of birth	Full-time student	Foster/step child*	Disabled or handicapped* child
1.				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Are additional children listed on separate page?  yes Please sign and date all pages.

\* Foster and stepchildren, eligibility is determined by employer. For disabled, handicapped children, complete the appropriate form.

**Health Information for All Coverages Being Applied for**

To prevent delays give full details to "yes" answers for everyone electing coverage. If more space is needed, attach a separate page giving full details. Sign and date all pages. All statements and descriptions on this form shall be deemed to be representations and not warranties.

Employee's height \_\_\_\_ ft. \_\_\_\_ in. weight \_\_\_\_ lbs. Spouse's height \_\_\_\_ ft. \_\_\_\_ in. weight \_\_\_\_ lbs.

1.  yes  no Is anyone planning or scheduled for hospitalization, surgery, medical treatment, therapy, counseling, medical tests or examinations or taking any medicine or is anyone pregnant (due date \_\_\_\_\_) any complications \_\_\_\_\_ C-Section date \_\_\_\_\_ Multiple births?  yes  no )

2.  yes  no In the past five years, has anyone had surgery, been hospitalized or consulted with a doctor, had blood or other diagnostic tests (other than for HIV antibody), or been advised to receive medical treatment OR been diagnosed or received treatment for any of the following conditions or disorders? (Check ALL that apply.) If a condition is not noted, please list it.

- [cancer]  [alcohol]/[drug use]  [arthritis]/[bone]/[joint]/[muscle]  [skin]/[eye]/[ear]/[nose]/[throat]
- [tumor]  [high cholesterol]  [allergy]/[asthma]/[respiratory]  [kidney]/[bladder]/[urinary]
- [infertility]  [heart]/[circulatory]  [digestive]/[intestinal]/[eating]  [stroke]/[neurological]/[nervous system]
- [liver]/[hepatitis]  [mental]/[nervous]  high blood pressure [– last reading and date \_\_\_\_ / \_\_\_\_ ]
- [diabetes – last HbA1c reading and date \_\_\_\_ / \_\_\_\_ ]  [organ or other transplants]
- [Acquired Immune Deficiency Syndrome (AIDS)/infection with HIV (Human Immunodeficiency Virus)/other immune disorder]
- [other – including other meds \_\_\_\_\_ ]
- [tobacco use (which applicant: \_\_\_\_\_ )]

Provide details for all "yes" answers. If more space is needed, attach a separate page giving full details. Sign and date all pages.

Name	Date diagnosed/treated	Length of illness or condition
Diagnosis of illness or condition	Type of treatment	
Any current symptoms or problems		
Names of all medications		
Names and addresses of doctors, hospitals or other providers		

Name	Date diagnosed/treated	Length of illness or condition
Diagnosis of illness or condition	Type of treatment	
Any current symptoms or problems		
Names of all medications		
Names and addresses of doctors, hospitals or other providers		

Name	Date diagnosed/treated	Length of illness or condition
Diagnosis of illness or condition	Type of treatment	
Any current symptoms or problems		
Names of all medications		
Names and addresses of doctors, hospitals or other providers		

**Authorization, Acknowledgment, and Signatures**

- I represent information, statements, and answers on this form, and any attachments, are complete and true to the best of my knowledge. They are a part of this request for coverage under the group policies. I agree Principal Life Insurance Company is not liable for anyone's claim which happens or begins before the effective date of coverage or approval of any life and disability coverage.
- I have read, or had read to me, the questions and responses and realize any false statements, omissions or material misrepresentation regarding age or health information could cause life and disability coverages, if issued, to be cancelled as never effective.
- Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement, may be guilty of insurance fraud.
- I understand all policy provisions for medical coverage will apply. If approved for life and disability coverages, all policy provisions will apply including, but not limited to, preexisting conditions restriction, the Actively at Work and Period of Limited Activity provisions.
- I understand an agent cannot change or waive any rates, benefits, or provisions of any policy, if issued, without the written approval of an officer of Principal Life.

- For life and disability coverages, I authorize any doctor, health care provider, hospital, clinic or medically related facility, insurance company, consumer reporting agency or employer, that has any personal information, including physical, mental, drug or alcohol use history, regarding me or any dependent, to give to Principal Life, its agents and employees performing business transactions, any such data.
- I authorize Principal Life to release any such data as required by law. When signed in connection with any application for, reinstatement of, or request for change in benefits, this form shall be valid for two years after the date shown below. I understand I may revoke this authorization for information not then obtained. A photocopy of this form shall be as valid as the original.
- I understand the data obtained by use of this authorization will be used by Principal Life for claims administration and to determine eligibility for life and disability coverage. This information will not be used for any purposes prohibited by law.

Employee's signature	Date signed
Spouse's signature*	Date signed

\*Spouse signature only required if Voluntary Term Life coverage is elected.

**Notice of Information Practices for Life and Disability Coverages**

In order to properly underwrite and consider your request for coverage, we must collect information to determine if you (and your dependents if also requesting dependent coverage) qualify for insurance with Principal Life. We will do this by having you complete this Health Statement. In addition, we may contact sources besides yourself for personal data about any proposed insured, including (a) spouse, (b) employer, (c) medical professionals or institutions, and (d) insurance companies to which you may have applied for insurance in the past. The personal data may include age, medical history, job, income, habits and other personal characteristic information. We may also ask that medical exams or other tests be completed.

We will keep your data confidential. Only employees performing business transactions regarding your coverage will see your data. In certain circumstances, we may provide data to (a) government agencies, (b) attending physicians, (c) insurance organizations without identification, and (d) the employer, if applicable, for the purpose of reporting claims experience or conducting audits.

You or your dependents, if applicable, have certain rights in connection with this request for coverage. Those rights are:

1. to find out what personal information is contained in Principal Life files (medical information may be disclosed only to your attending physician).
2. to correct or amend information in Principal Life files.

Upon written request, Principal Life will furnish to you (or your dependent) information concerning:

1. the nature and scope of personal data in our records;
2. the types of disclosures which may be made; and
3. rights of access to the information collected and how such information may be corrected or amended.

We will respond to such written request within 30 days from the date of receipt.

For further information about your file or rights, you may contact: Group Operations, Medical Underwriting, Principal Life Insurance Company, Des Moines, IA 50392-0432.

**Instructions for Employee**

After this form is completed and signed, send original to Principal Life Insurance Company, Des Moines, IA 50392-0002, and make a copy for your records.