Principal Financial Group

Mailing Address:
Marsh Affinity Group Service
P.O. Box 9356
Des Moines, IA 50306-9356

Principal Life Insurance Company

Request for Payroll Deduct Group Universal Life Insurance

Employee's name (last, first, middle initial)	Social security number	Birthdate
Spouse's name (last, first, middle initial)	**Social security number**	**Birthdate**
Mailing address	**Employer (insured)**	**Employer (spouse)**
City **State** **ZIP code**	**Home telephone number**	

Employee Information **FOR HELP OR INFORMATION CALL US TOLL FREE AT** ☎ 1-800-255-6614

☐ male ☐ female | Annual salary | Date of hire

Pay frequency ☐ weekly ☐ bi-weekly ☐ semi-monthly ☐ monthly

Employee Coverage (For coverage amount in excess of the guaranteed coverage or if applying after your eligibility period, please complete the Statement of Health on Page 2.)

Coverage amount as a multiple of your salary:	Monthly contribution to the certificate account	
☐ 1x ☐ 2x ☐ 3x ☐ 4x ☐ 5x	☐ $10 ☐ $20 ☐ $30 or specify amount $ _____	
Name of beneficiary & relationship to employee	**Accidental death benefit**	**Have you used any type of tobacco in the past 12 months?**
	☐ yes ☐ no	☐ yes ☐ no

Spouse Coverage (For coverage amount in excess of the guaranteed coverage or if applying after your eligibility period, please complete the Statement of Health on Page 2.)

Amount coverage	Monthly contribution to the certificate account	
$ _____ ($1,000 increments)	☐ $10 ☐ $20 ☐ $30 or specify amount $ _____	
(Beneficiary for spouse's coverage is employee unless changed.)	**Accidental death benefit**	**Have you used any type of tobacco in the past 12 months?**
	☐ yes ☐ no	☐ yes ☐ no

Dependent Children Coverage

Dependent children insurance in the amount of $10,000 per child ☐ yes ☐ no

Beneficiary for children's coverage is the employee unless changed.

(For coverage amount in excess of the guaranteed coverage or if applying after your eligibility period, please complete the Statement of Health on Page 2.)

I hereby subscribe to the Group Universal Life Insurance Trust. I certify that I am eligible under the provisions of the program and request to be insured. I understand the group policy is issued in and governed by the laws and regulations of the state of Missouri.

I certify that all information, statements, and answers on this request for insurance are true and complete to the best of my knowledge. These representations may be relied upon in evaluating my request for insurance. I understand that omissions or misstatements regarding age or medical history could cause an otherwise valid claim to be denied and/or void the insurance, if issued.

I understand that, as the employee, the insurance I and my dependents have applied for will begin on the effective date identified in the schedule of benefits, provided that I am actively at work on that date. If I am not actively at work on such date, coverage will not go into effect until after my return to work. Furthermore, I understand that no insurance will become effective for any member of my family, while he/she is in a period of limited activity. Period of limited activity means any period of time which a person is confined in a Health Care facility, or, whether confined or not, is unable to carry on the regular and usual activities of a healthy person of the same age and sex.

Employee signature	Date
X	
Spouse signature (If spouse coverage elected)	Date
X	

STATEMENT OF HEALTH

(To be completed ONLY by those persons requesting coverage in excess of the guaranteed coverage or those persons applying after their enrollment period)

Employee	Spouse
height _____ ft. _____ inches weight _____ lbs.	height _____ ft. _____ inches weight _____ lbs.

1. Is any applicant getting or thinking about getting medical treatment, taking any medicine, drugs, pills, shots, etc? ☐ yes ☐ no
2. Has any applicant in the past 10 years had or been told he/she has:
   a. chest pains, heart trouble, heart attack, heart murmur? ☐ yes ☐ no
   b. high blood pressure, cancer, or tumors? ☐ yes ☐ no
   c. nervous, respiratory, circulatory, digestive, urinary or genital-urinary problems? ☐ yes ☐ no
   d. venereal disease or other infectious disease? ☐ yes ☐ no
   e. diabetes, pneumonia, or disorder or the lymph system? ☐ yes ☐ no
   f. AIDS, AIDS-related complex or immune disorder? ☐ yes ☐ no
3. In the last 5 years has any applicant had surgery, been hospitalized or to a doctor, had blood or other diagnostic tests? ☐ yes ☐ no

THIS SECTION MUST BE FULLY COMPLETED FOR ALL "YES" ANSWERS ABOVE
(If additional space is needed, please attach a separate piece of paper.)

Question number	Name	Nature of illness or injury, treatment, testing or medical attention, etc.	Date		Duration	Diagnosis, results, findings or remaining effects	Names and addresses of physicians or hospitals
			mo	yr.			

I authorize any medical doctor, health care provider, hospital, clinic, or other medical related facility, insurance company, or any other organization, institution or person to give to Principal life Insurance Company or its reinsurers any information about me or any named dependents, including physical or mental history and drug or alcohol abuse A photocopy of this authorization shall be as valid as the original. I understand I may revoke this authorization, by sending a written notice to Principal Life home office.

I understand that insurance in excess of the amount guaranteed to be issued for myself and my dependents will not become effective, notwithstanding the actively at work and period of limited activity provisions, unless medical history is evaluated and satisfactory to Principal Life.

Employee signature	Date
X	
Spouse signature (If spouse coverage elected)	Date
X	