



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

Principal Life  
Insurance Company

Statement of  
Health - TX

Account number

**Instructions**

1. The Employee Information section should always be completed with the information about the employee.
2. The employee must ALWAYS sign the last page of this form.
3. When coverage is being requested for an eligible dependent(s), note that this form applies to all persons requesting coverage.
  - a. Complete the Eligible Dependent Information section, if applicable.
  - b. Complete the Health Information section for you and your eligible dependents, if applicable.
  - c. The spouse or domestic partner must sign the last page of this form if spouse or domestic partner coverage is being requested.
4. After completing and signing this form, make a copy for your records.

Why is this Statement of Health being submitted?

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

**Employee Information**

Your name (last, first, middle initial)	Gender <input type="checkbox"/> male <input type="checkbox"/> female	Social security number	Date of birth
Home address (street)			
City	State	ZIP code	
Home phone number	Company name Talent Logic Inc		

**Eligible Dependent Information**

Name (last, first, middle initial)	Gender <input type="checkbox"/> male <input type="checkbox"/> female	Social security number	Date of birth
	<input type="checkbox"/> male <input type="checkbox"/> female		
	<input type="checkbox"/> male <input type="checkbox"/> female		
	<input type="checkbox"/> male <input type="checkbox"/> female		
	<input type="checkbox"/> male <input type="checkbox"/> female		
	<input type="checkbox"/> male <input type="checkbox"/> female		
	<input type="checkbox"/> male <input type="checkbox"/> female		
	<input type="checkbox"/> male <input type="checkbox"/> female		

If additional dependents, list on separate page. Please sign and date the separate page.

**Health Information**

To prevent delays give full details to "yes" answers for everyone requesting coverage. If more space is needed, attach a separate page giving full details. Sign and date all those pages.

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

Spouse's or domestic partner's height \_\_\_ ft. \_\_\_\_\_ in. weight \_\_\_ lbs.

2.  yes  no Is any person receiving medical treatment or taking medication?
3.  yes  no Is any person currently pregnant?
4.  yes  no In the past 5 years, has any person had surgery, been hospitalized or consulted with a physician or medical practitioner, had blood or other diagnostic tests (other than for HIV antibody), or been advised to receive medical treatment? Provide results of all tests.
5.  yes  no In the past 5 years, has any person been diagnosed with or received treatment for any of the following (check all that apply)?
- |  |   |   |  |
|--|---|---|--|
| <input type="checkbox"/> cancer                        | <input type="checkbox"/> liver disorder                           | <input type="checkbox"/> bone/joint disorder                | <input type="checkbox"/> psychological/mental disorder |
| <input type="checkbox"/> tumor(s)                      | <input type="checkbox"/> kidney/urinary disorder                  | <input type="checkbox"/> respiratory disorder               | <input type="checkbox"/> blood disorder                |
| <input type="checkbox"/> heart or circulatory disorder | <input type="checkbox"/> muscle disorder                          | <input type="checkbox"/> infertility                        | <input type="checkbox"/> hepatitis                     |
| <input type="checkbox"/> stroke                        | <input type="checkbox"/> multiple sclerosis/neurological disorder | <input type="checkbox"/> skin/eyes/ear/nose/throat disorder | <input type="checkbox"/> organ or other transplants    |
| <input type="checkbox"/> alcohol/drug use              | <input type="checkbox"/> digestive disorder                       | <input type="checkbox"/> gland disorder                     |  |
- High blood pressure – last reading and date \_\_\_\_\_ / \_\_\_\_\_
- Diabetes – last HbA1c reading and date \_\_\_\_\_ / \_\_\_\_\_
- Other – including medication \_\_\_\_\_
6.  yes  no In the last 5 years, has any person had, been treated for or been diagnosed as having HIV (Human Immunodeficiency Virus) infection, positive HIV test or AIDS (Acquired Immune Deficiency Syndrome)?

If applying for Critical Illness, complete question 7.

7.  yes  no Have any of your natural parents, brothers or sisters been diagnosed with coronary artery disease, stroke, diabetes or invasive cancer prior to age 55?
- Employee – if yes, disease and age at diagnosis: \_\_\_\_\_
- Spouse or domestic partner – if yes, disease and age at diagnosis: \_\_\_\_\_

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

Name	Date diagnosed/treated	Length of illness or condition
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Diagnosis of illness or condition	Type of treatment, including medications
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Describe current symptoms or problems

Names of all current medications

Names and addresses of physicians, medical practitioners, hospitals or other health care providers

**Health Information (continued)**

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Name	Date diagnosed/treated	Length of illness or condition
Diagnosis of illness or condition	Type of treatment, including medications	
Describe current symptoms or problems		
Names of all current medications		
Names and addresses of physicians, medical practitioners, hospitals or other health care providers		

Name	Date diagnosed/treated	Length of illness or condition
Diagnosis of illness or condition	Type of treatment, including medications	
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Diagnosis of illness or condition	Type of treatment, including medications	
Describe current symptoms or problems		
Names of all current medications		
Names and addresses of physicians, medical practitioners, hospitals or other health care providers		

In order to properly underwrite and consider your request for coverage, we must collect information to determine if you (and your dependents if also requesting dependent coverage) qualify for insurance with Principal Life Insurance Company. We will do this by having you complete this Statement of Health. In addition, we may contact sources besides yourself for personal data about any proposed insured, including (a) spouse or domestic partner, (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, (d) the employer, and (e) our reinsurer, if applicable, for the purpose of reporting claims experience or conducting audits.

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

1. to 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, Group Medical Underwriting, Principal Life Insurance Company, 711 High Street, Des Moines, IA 50392-0531.

**Authorization, Acknowledgment, and Signatures**

- I represent information, statements, and answers on this form, and any attachments, are complete and true to the best of my knowledge. They are a part of this request for coverage under the group policies. I agree Principal Life is not liable for anyone's claim which happens or begins before the effective date and approval of coverage.
- I have read, or had read to me, the questions and responses and realize any false statements, omissions or material misrepresentation regarding age or health information could cause coverage, if issued, to be 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.
- If approved for coverage, all policy provisions will apply including, but not limited to, preexisting conditions restriction, the Actively at Work and Period of Limited Activity provisions.
- I understand an agent cannot change or waive any rates, benefits, or provisions of any policy, if issued, without the written approval of an officer of Principal Life.
- I authorize any physician, medical practitioner, health care provider, hospital, clinic or medically related facility, insurance company, consumer reporting agency or employer, that has any personal information, including physical, mental, drug or alcohol use history, regarding me or any dependent, to give to Principal Life, its agents, employees or reinsurers performing business transactions, any such data.
- I authorize Principal Life to release any such data as required by law. When signed in connection with any application for, reinstatement of, or request for change in benefits, this form shall be valid for two years after the date shown below. 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 coverage. This information will not be used for any purposes prohibited by law.

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