Principal Life Insurance Company
P.O. Box 14455
Des Moines, IA 50306-3455

Application for Disability Insurance Benefit Update Offer/ Future Benefit Increase Offer

1. Name of Insured ____________________ Policy Number ____________________

2. Employer ____________________ Occupation/Duties ____________________

3. Report past income as shown on Federal Income Tax Return.

Earned Income:

	Year to Date	Actual Last Year
a. Salary, Wages, Commissions & Bonus (W-2 and/or 1099 Form)	$ ________	$ ________
b. Sole-Proprietor (Net income on Form 1040, Schedule C)	________	________
c. Partner or member of Limited Liability Company (LLC) (Schedule K-1 or Form 1040, Schedule E)	________	________
d. Owner of S-Corp or C-Corp (Schedule K-1 or Form 1040, Schedule E, or Pro rata share of C-Corp net profits per Form 1120)	________	________
e. Pension and Profit Sharing Contributions	________	________

4. **Unearned Income** – Includes capital gains, interest, dividends, net rental income, pensions, annuities, and alimony.
Is unearned income greater than 10% of earned income, or $30,000? ☐ Yes ☐ No
If Yes, itemize: ____________________

5. **Net Worth** – Is net worth, excluding primary residence, greater than $6,000,000? ☐ Yes ☐ No
If Yes, itemize: ____________________

6. **Premium Payor**
   a. Premium paid by: ☐ Insured _____ % ☐ Employer _____ %
   b. If your employer pays any part of the premium, is it reportable by you as taxable income? ☐ Yes ☐ No

7. **Other Coverage** – Do you have any other Disability Coverage in force other than this policy? ☐ Yes ☐ No

If yes, please describe all disability coverage in force, other than this policy. Indicate if it is: **A) Individual, B) Association, C) Group, D) Salary Continuation, E) Overhead Expense, or F) Buy-Out**. Please include coverage for which you will become eligible in the next 3 years after a qualifying period of employment has been met.

Company or Source	Type (A, B, C, etc.)	Monthly Benefit Amount	Elim. Period	Benefit Period	Will Coverage Be Replaced?	Effective Date of Cancellation
					☐ Yes ☐ No	
					☐ Yes ☐ No	
					☐ Yes ☐ No	

Authorization

I represent that all statements in this application are true and complete to the best of my knowledge and belief. I have submitted no money with this application. I understand that the statements in this application are the basis of this Benefit Update Offer/Future Benefit Increase Offer. I have received a copy of "Notice of Insurance Information Practices". It includes notice required by any Fair Credit Reporting Act and describes Medical Information Bureau, Inc. (MIB, Inc.). I authorize the release of any records or knowledge of me from any insurance company, institution, person, organization, or MIB, Inc. to the Principal Life Insurance Company and/or its reinsurers. This authorization shall be valid for 24 months from the date of this application. A copy of this authorization shall be as valid as the original.

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 and Title of Owner (if other than Insured) ____________________ Signature of Insured ____________________

Signed at: City ____________________ State ________ Date ________