FIRST PLACE

PRELIMINARY UNDERWRITING INQUIRY

THE BEST OFFERS
FROM THE BEST CARRIERS
AT THE BEST PRICE
THE FIRST TIME

Corporate Headquarters
3700 Embassy Parkway
Suite 450
Akron, OH 44333
800.792.6795

Cleveland Office
4700 Rockside Road
Suite 430
Independence, OH 44131
800.759.5433

www.buaweb.com

Underwriting is the most important aspect of product pricing in the insurance industry. Put BUA's experience to work for your client.

Complete the First Place Preliminary underwriting Inquiry and set yourself apart from the competition.

Our In-House Underwriter will review the facts and shop your case for the best possible offers. Medical records may be ordered on cases with an annual premium over $5,000.

A few minutes today can save you and your clients time and money.

UNDERWRITING. UNDERSTOOD.

This is not an application for life insurance

First Place Preliminary Underwriting Inquiry

This First Place Preliminary Underwriting Inquiry form is used exclusively to gather specific information on a proposed insured's medical history and other factors that may impact underwriting and rating classification. This is not an application for insurance and in no way guarantees a specific underwriting class or binds any insurance coverage with any insurance carrier.

Proposed Insured's Signature ____________________

Personal Information

Name ____________________ ☐ Male ☐ Female Soc. Sec. # ____________
Address ____________________City__________State______Zip ______
Date of Birth__________ U.S. Citizen? ☐ Yes ☐ No
If no, country of citizenship and type of VISA______________Date entered into U.S.? __________
Occupation ______________ Annual Income $__________ Net Worth $ __________

Have you recently applied for insurance? ☐ Yes ☐ No
If yes, type of insurance, underwriting decision, and reason?
____

Provide details on pending and in-force coverage:

Company	Policy# Or Application	Amount	Class/Rating Issued:	Current Premium	Date issued	Do you intend to replace?
						Y / N
						Y / N
						Y / N

Plan of Insurance

☐ Universal Life ☐ Whole Life ☐ Index UL ☐ Variable Life ☐ Term, Level Period ______
☐ Survivorship *Please have other proposed insured submit First Place as well*
☐ Annuity ☐ Disability Income: Monthly Benefit Amount__________ ☐ LTC

Face amount desired: $__________ Premium amount desired: $__________ ☐ Annually ☐ Monthly

If you are replacing coverage, will there be any 1035 money with this replacement? ☐ Yes ☐ No
If yes, Gross 1035 $ ________ Loan, if any $ ________ Basis $ ________

What is the purpose of this coverage? *Check all that apply*
☐ Buy/Sell ☐ Key Person ☐ Estate Planning ☐ Income Replacement ☐ Charitable Planning
☐ Executive Benefits ☐Other ______________

Who is to be primary beneficiary? ______________ Relationship:______________
Contingent beneficiary? ______________ Relationship: ______________
Owner? ______________ Payor? ______________

Medical History

1. Height: _____Weight: ______ If you have lost any weight this year, amount and reason: ______________________

2. Have you ever used tobacco or any other nicotine products? □ Yes □ No
   If yes, in what form? ____________________________________ Date of last usage: ________________________________
   If cigars, how many per year? ___________________

3. Have you been convicted of a DUI and/or had or more then 1 moving violation in the past 3 years? □ Yes □ No
   If yes, please give the type and date(s) of violations

4. Please list all current medications and frequency.

   ____________________________ ____________________________ ____________________________
   ____________________________ ____________________________ ____________________________
   ____________________________ ____________________________ ____________________________
   ____________________________ ____________________________ ____________________________
   ____________________________ ____________________________ ____________________________

5. Who is your primary care physician? ____
Address ____ Phone _______________________
Date of last visit: ______________ Reason: ____

6. What other physicians have you consulted during the past five years and why? Please also provide name and address of facility and date of last visit.

   ____ _______
   ____ _______
   ____ _______
   ____

7. Has any parent or sibling been diagnosed with heart disease, stroke, cancer, polycystic kidney disease or Huntington's disease?
   □ Yes □ No

Relation to Insured	Disease	Age at Onset	Age (if Living)	Age at Death

8. Do you currently drink alcohol? □ Yes □ No
   If yes, date last used?_______ Amount per week?____________________
   Have you ever consulted a doctor or received treatment because of your alcohol use? □ Yes □ No
   If yes, please provide date(s): ______________________________
   Are you an active member of a support group such as AA? □ Yes □ No
   Have you ever had a relapse? □ Yes □ No If so, when? _____________________

9. Have you ever used illegal drugs or used prescription drugs other than prescribed? □ Yes □ No
   Name of drug(s):____
   Date of last use: ____
   Have you ever sought treatment for drug use? □ Yes □ No - ***If Yes,*** where and when?_____________________________
   Are you an active member of a support group? □ Yes □ No
   Have you ever had a relapse? □ Yes □ No If so, when? _____________________

10. Have you ever been diagnosed with coronary artery disease, or had a heart vessel bypass/stent? ☐ Yes ☐ No

Name of cardiologist or physician treating and date last seen:_______________

Date of diagnosis: _______________ Number of diseased vessels: __________

Which vessels, if known: _______________ Were you treated surgically? ☐ Yes ☐ No

If yes, when? _______________

Check the procedure(s) you had:

☐ Angioplasty with stenting (how many?) _______ ☐ Bypass (how many?)__________

Date of last cardiac testing: _______________ Results: _______________

Any chest pain since treatment/surgery? ☐ Yes ☐ No

11. Have you ever been diagnosed with sleep apnea? ☐ Yes ☐ No

Date of diagnosis: _____________ Severity: ______________ Date of last sleep study: _______________

Treatment_______________ If CPAP or BIPAP, do you use regularly? Y/N

12. Have you ever had cancer or a tumor? ☐ Yes ☐ No

Exact name and location of cancer or tumor: _______________

Stage and grade: _______________

Who would have the pathology report? _______________

Dates of treatment/surgery: _______________

Any recurrence? _______________

Do you have at least an annual follow-up? ☐ Yes ☐ No With whom? _______________

13. Have you ever been diagnosed with diabetes? ☐ Yes ☐ No

If yes, check which type: ☐ Type I ☐ Type II ☐ gestational diabetes

Date of diagnosis: _______________

Treatment (check all that apply): ☐ Diet Only ☐ Oral Medication ☐ Insulin

What was your last hemoglobin A1c level? _______________

Please check any and all complications you've had related to your diabetes:

☐ eye trouble ☐ kidney trouble ☐ neuropathy/extremity pain ☐ hospitalizations ☐ ulcers

14. Please check any/all of the following impairments with which you have been diagnosed and provide details:

☐ **Cardiovascular:** hypertension, stroke, TIA, carotid disease, peripheral vascular disease, heart valve disorder, abnormal heart rhythm, cardiomyopathy, or any other cardiovascular disease not listed

☐ **Gastrointestinal:** esophagus, stomach, colon, liver, pancreas, other gastrointestinal disease not listed

☐ **Pulmonary**: asthma, COPD, emphysema, sarcoidosis, other pulmonary disease not listed

☐ **Mental/nervous:** depression, anxiety, bipolar, ADD, fainting, seizures, brain tumor, multiple sclerosis, other

☐ **Musculoskeletal:** osteoarthritis, rheumatoid arthritis, lupus, connective tissue disorder, chronic pain, back disorder, other musculoskeletal disease not listed.

☐ **Any disorder of:** kidney, urinary tract, blood or circulatory system, immune system, reproductive system, skin, eye, ear, any disorder not otherwise specified.

14. *continued* Details to include:

____

____

____

____

____

15. Do you:

- □ Participate in regular aerobic exercise
- □ Follow a healthy diet
- □ Have age-appropriate screening tests with normal results (mammogram, colonoscopy, etc)
- □ Have regular checkups with your physician
- □ Have normal blood pressure and cholesterol levels? If so, please list, if known
  Blood pressure ___________ Total cholesterol ___________ Cholesterol/ HDL ratio ____________

Nonmedical History

1. Are you now or have you ever been a pilot or a crew member on a plane or helicopter? □ Yes □ No
   If yes, type of aircraft: ________________________________ Private or commercial? ____________________________
   How many hours do you fly per year? ____________ Number of solo hours flown ________________
   Do you have an IFR (instrument flight rating)? □ Yes □ No Have you ever been grounded? □ Yes □ No

2. Please check any and all of the activities in which you've participated in the last five years
   □ Scuba diving □ Bungee jumping □ Sky Diving □ Mountain Climbing □ Hang Gliding
   □ Auto/Motorcycle Racing □ Other

Date of last participation? _______________________ Are you a member of any sanctioned club? □ Yes □ No

Additional details: ____
____
____

3. Have you ever filed bankruptcy? □ Yes □ No If yes, what chapter?_______Date of discharge? _________________

4. Have you ever been charged with a criminal offense? □ Yes □ No
   If yes, was it a misdemeanor or felony? ___________________ When were you charged? ___________________
   What was the offense? ____
   What was the sentence? ____
   Have you completed your obligation to the court? □ Yes □ No
   Have you served a probation sentence? □ Yes □ No
   If yes, are you currently serving? □ Yes □ No Dates on probation: __________________

Additional details:
____
____
____

5. Have you traveled to any foreign country in the past two years? □Yes □No
   Country/City_______________________ Purpose_______________________ Duration ________________
   Do you have any future plans of foreign travel in the next two years? □Yes □No
   Country/City_______________________ Purpose_______________________ Duration ________________

Agent Information – (this section must be completed)

Name:____ ____
Phone No.:____ Fax No.:____
Address____City____________________State_______Zip _______________
Email Address: ____

Business Underwriters Associates, L.L.C.

Authorization to Obtain Information

Waiver and Acknowledgement

AUTHORIZATION:

I AUTHORIZE *(primary care physician name)* ____________________________, OR any health physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, or other health care provider (My providers) that has provided treatment or services to me or on my behalf to disclose my entire medical record and any other protected health information concerning me to Business Underwriters Associates, LLC and any of its affiliates, agents, employees, and representatives. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

By signing below, I terminate any agreements I have made with My Providers to restrict my protected health information and I instruct My Providers to release and disclose my entire medical records without restriction.

I UNDERSTAND my protected health information is to be disclosed under this Authorization so that BUA may:
1) underwrite my applications for coverage by making eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain insurance; and 3) conduct other legally permissible activities that relate to any coverage I have or have applied for with the Insurance Companies named below:

Accordia/Global Atlantic
Aetna Life
AIG Life
AIG American General
Allianz
Allmerica Financial
American Investors
American Life & Casualty
American National
Assurity
AXA Life
Banner Life
Brighthouse Financial
Canada Life
Central National
Citizens Security
Cologne Life Reinsurance
Colorado Bankers
Companion Life of NY
Coventry First
Equitable of Iowa
Federal Home
Fidelity & Guaranty
Fidelity Security
Fort Dearborn
Fortis
Genworth Financial
Genworth Life & Annuity
Genworth Life of NY
Gleaner
Illinois Mutual
ING USA Life & Annuity
Integrity Life
Interstate Assurance
Jefferson Pilot
John Hancock
Lafayette Life
Life of Virginia
Life Settlement Alliance
Lincoln Benefit Life
Lincoln Life & Ann. of NY
Lincoln National
Lincoln National Rein. Co.
Manulife
Mass Mutual
Minnesota Life
MONY Life Insurance Co.
Mutual of Omaha
North American
North American of NY
National Guardian
National Integrity
Nationwide
New York Life
Old Republic
Pacific Life
Penn Mutual
Penn Treaty
PFL
Physicians Mutual
Principal Life Insurance
Principal National Life
Protective Life
Provident Mutual
Prudential Ins Company of America/Pruco Life Ins Co
Rumson Capital
Reliance Standard
Security Life of Denver
Reinsurance Co.
Security Mutual
State Life
Stonestreet Financial
Sun Life of Canada
Sun Life/ Keyport
Symetra
Transamerica
United of Omaha
US Life
Voya
Voya of NY
Western Reserve Life
William Penn of NY
Zurich American Life Insurance Company
Zurich American Life Insurance Company of New York

Other Insurance Company: ____

This authorization shall remain in force for 24 months, beginning _______________________. A copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization at any time. I understand my revocation must be in writing and addressed to the attention of the Privacy Official at the above-named facility or BUA, 3700 Embassy Pkwy, Ste 450, Akron, Oh 44333. I understand that any information that is disclosed pursuant to this authorization may be redisclosed and no longer covered by certain federal rules governing privacy and confidentiality of health information.

WAIVER AND ACKNOWLEDGMENT:

This waiver and Acknowledgement (the "Waiver") has been signed on the date set forth below by the undersigned (the "Applicant") in favor of BUA, its successors, assigns, shareholders, directors, and employees (collectively "BUA")
Applicant acknowledges, understands and agrees as follows:

- that applicant has filed an application with BUA intending to secure life insurance from one or more insurance underwriters.
- that, in the course of applying for life insurance coverage, BUA has asked for and received information concerning Applicant's medical condition and history, as well as other information that is of a personal and confidential nature.
- that BUA will provide that information, or parts of it, to a number of potential insurers and their agents, employees, employees and representatives.
- that BUA maintains, or will maintain, an electronic data interchange (the "interchange") through which certain Authorized underwriters and /or other insurance industry representatives (referred to in this Waiver as "Underwriters") may gain access to information concerning persons either covered by or applying for coverage by or applying for coverage under insurance through policies issued and serviced by those Underwriters.
- that BUA will use the Interchange to store some or all of the confidential and personal information Applicant has provided to BUA, and, therefore, that Underwriters will be able to gain access to that information through the Interchange.
- that the Underwriters will gain access to the Interchange via the Internet or other, similar computer-based telecommunications systems.
- that, even though BUA has in place security measures BUA believes appropriate to protect the Interchange and the information it contains from unauthorized access and use, and even though BUA will continue to upgrade those security measures from time to time as circumstances warrant, BUA can make no guarantee as to BUA's ability to protect the Interchange and the information it contains from unauthorized access by "hackers" or other persons, who, through wrongful means, pay bypass the security measures protecting the integrity of the Interchange.
- that BUA cannot control the use, dissemination, publishing or interpretation of the information contained in the Interchange that information is gathered by an Underwriter.
- that Applicant will hold harmless from and against any unauthorized access to or use of, by any person or company, any information pertaining to Applicant in BUA's possession and /or stored on the Interchange.
- that Applicant will indemnify BUA for all costs and expenses incurred by BUA or any of its employees, shareholders, directors, agents or representatives in enforcing this Waiver.

Applicant has evidenced his/her acknowledgement, understanding, and agreement with respect to the foregoing by signing this document below.

I ACKNOWLEDGE that I have received a copy of this document.

I AGREE this form shall be valid for twenty-four months (24) from the date shown below.

Signed on this date: ________/________/__________

City: ____ State: ______________________________

x ____
Signature of Proposed Insured/Parent or Guardian

x _____________________________________
Signature of Witness

____
(Printed name of Proposed Insured/Parent or Guardian)

At Business Underwriters Associates LLC, protecting your privacy is very important to us. We are strongly committed to safeguarding the information you provide us and to use it responsibly. Because of your commitment to you, we have adopted and adhere to the following policy regarding the privacy of your personal information.

COLLECTION OF INFORMATION

We may collect nonpublic personal financial information about you from some or all of the following sources:

- Information we receive from you on applications, new account forms, and fact-finding questionnaires;
- Your transactions with us, our affiliates, and those product sponsors with whom we have vendor agreements or other arrangements for the provision of services to you.
- Information we receive from non-affiliated third parties, including, but not limited to consumer reporting agencies; and
- Affiliated and unaffiliated product sponsors with whom we have selling relationships and whose products you own.

DISCLOSURE OF INFORMATION

We will not share nonpublic personal information concerning our potential, current, or former customers with affiliated or unaffiliated third parties, except as permitted by law. Nor will we share this information for marketing purposes, except as permitted by law.

Generally, we may disclose customer nonpublic personal information to affiliates and non-affiliated third parties that provide services to us or have contracts with us to supply the products or services that you have requested through us. Examples of third parties with whom we may share your information include:

- Insurance companies, mutual fund companies, insurance support organizations, and other product sponsors to effect purchases and sales and allow for the servicing of your accounts;
- Your agent or broker/dealer;
- Clearing agencies through whom we clear and settle securities transactions;
- Third party investment advisory firms with whom we have relationships for the management of customer advisory accounts;
- Business, like banks and other financial institutions with whom we have an agreement for the marketing and sale of products and services;
- Regulatory or law-enforcement authorities; and
- Record keeping companies.

Where we share your nonpublic personal information with third parties for the purposes noted above, we ensure that there are contractual restrictions on their use and disclosure of that information.

PROTECTION OF INFORMATION

We have security practices and procedures in place to prevent unauthorized use or access to your nonpublic personal information. Within BUA, your information is only available to those individuals requiring access to process or service your transaction with us, and those fulfilling compliance, legal or audit functions on our behalf. We maintain physical, electronic, and procedural safeguards to ensure the protection of your nonpublic personal information in accordance with state and federal privacy regulations.

HIPAA Authorization

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT ("HIPAA")
Authorization to Obtain and Disclose Information

______________________________   ____/____/____

Name of Insured/Proposed Insured (Please Print)   **Date of Birth**

I, the Insured/Proposed Insured above or the Insured/Proposed Insured's Personal Representative acting on behalf of the Insured/Proposed Insured, hereby authorize all of the people and organizations listed below to give American General Life Insurance Company ("AGL"), The United States Life Insurance Company in the City of New York ("US Life"), and any affiliated company, (AGL, US Life and affiliated companies collectively the "Companies"), and their authorized representatives, including agents and insurance support organizations, (collectively, the "Recipient"), the following information:

- any and all information relating to my health (except psychotherapy notes) and my insurance policies and claims, including, but not limited to, information relating to any medical consultations, treatments, or surgeries; hospital confinements for physical and mental conditions; use of drugs or alcohol; drug prescriptions; and communicable diseases including HIV or AIDS; and
- information about me, including my name, address, telephone number, gender and date of birth

I hereby authorize each of the following entities ("Providers") to provide the information outlined above:

- any physician, nurse or medical practitioner or practitioner group;
- any hospital, clinic, other health care facility, pharmacy, or pharmacy benefit manager;
- any insurance or reinsurance company (including, but not limited to, the Recipient or any of the Companies (as defined above) which may have provided me with life, accident, health, and/or disability insurance coverage, or to which I may have applied for insurance coverage, but coverage was not issued);
- any consumer reporting agency or insurance support organization;
- my employer, group policy holder, or benefit plan administrator; and
- the Medical Information Bureau (MIB).

I understand that the information obtained will be used by the Recipient to:

- determine my eligibility for insurance;
- underwrite my application for insurance;
- determine my eligibility for benefits;
- if a policy is issued, determine my eligibility for benefits and contestability of the policy; and
- detect fraud or abuse or for compliance activities, which may include disclosure to MIB and participation in MIB's fraud prevention or fraud detection programs.

I hereby acknowledge that the Companies are subject to certain federal privacy regulations. I understand that information released to the Recipient will be used and disclosed as described in the Notice of Health Information Privacy Practices, but that upon disclosure to any person or organization that is not a health plan or health care provider, the information may no longer be protected by federal privacy regulations.

I understand that the Recipients requesting access to my (electronic or paper) medical records are acting as a patient authorized representative and will attempt to access my medical records in an efficient manner, including electronic interchange through a Health Information Exchange or directly through my Providers' electronic health record system.

I may revoke this authorization at any time, except to the extent that action has been taken in reliance on this authorization or other law allows the Recipient to contest a claim under the policy or to contest the policy itself, by sending a written request to: American General Life Companies Service Center, P.O. Box 9000, Amarillo, TX 79105-9000. I understand that my revocation of this authorization will not affect uses and disclosures of my health information by the Recipient for purposes of underwriting, claims administration and other matters associated with my application for insurance coverage and the administration of any policy issued as a result of that application.

I understand that the signing of this authorization is voluntary; however, if I do not sign the authorization, the Companies may not be able to obtain the information necessary to consider my application.

This authorization will be valid for 24 months. A copy of this authorization will be as valid as the original. I understand that I am entitled to receive a copy of this authorization.

Signature of Insured/Proposed Insured or Insured/Proposed Insured's Personal Representative

X

Signed on (date) ______________________

Signor name (printed) ______________________

Relationship ______________________

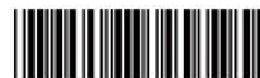
Description of Authority of Personal Representative

(if applicable) ______________________

____

Control Number/Policy Number ______________________

____



AGLC100633 Rev0716

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

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

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

Authorization for Release of Personal Health Information – All States
(Applicable to Individual Life and Disability Insurance Customers)

This authorization complies with the HIPAA Privacy Rule and permits health care providers and other covered entities to disclose personal health information.

____ / / __________
Name of Proposed Insured/Patient (please print) Date of Birth

I authorize any physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, health care provider, health plan, insurer, and/or any other entity subject to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) that has provided treatment, service, or coverage to me within the past 10 years to disclose my entire medical record to the Company, its agents, employees, insurance support organizations, reinsurers, and their representatives. This includes information concerning the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness (excluding psychotherapy notes as defined under HIPAA) and the use of alcohol, drugs, and tobacco. *Statements required by §164.508(c)(1)(ii), (c)(1)(iii).*

I understand my personal health information may be used or disclosed as set forth by this authorization. Protected health information includes information created or received by the Company. Protected health information also includes but is not limited to: hospital records, treatment records/office notes, alcohol or drug abuse treatment, consultation reports, workers' compensation information, diagnosis, prescriptions, test results, vocational testing/counseling information, benefit information, claims information, demographic information, and claims payment information. *Statement required by §164.508(c)(1)(i).*

By my signature, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct any physician, health care professional, hospital, clinic, medical facility, other health care provider or health plan, insurer, or other entity subject to HIPAA to release and disclose my medical record without restriction. I understand that my personal information, including my protected health information disclosed under this authorization, will be incorporated into and made a part of any life and/or disability insurance policy(s) issued by the Company in connection with the application(s) for insurance that I have submitted to the Company. I further understand that the policy(s) will be delivered to the policy owner, which may be my employer or other party. The information included and forming a part of such policy(s), including my protected health information, may be disclosed to the policy owner.

I understand that unless prohibited by state and/or federal law the protected health information is to be disclosed under this authorization so that the Company may: 1) underwrite my application for coverage, make eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage; and 5) conduct other legally permissible activities that relate to any coverage I have, have applied for, or may in the future apply for with the Company. *Statement required by §164.508(c)(1)(iv).*

The following groups of persons employed or working for the Company may use my personal health information which is described above: employees of the underwriting, administration, claim or legal departments and any other personnel of the Company, and its authorized representatives, and business associates that perform functions or services that pertain to any coverage I have, have applied for, or may in the future apply for with the Company. *Statement required by §164.508(c)(1)(ii).*

I understand any information disclosed under this authorization may no longer be covered by the privacy provisions of HIPAA and may be subject to redisclosure. *Statement required by §164.508(c)(2)(iii).*

This authorization shall remain in force for 24 months following the date of my signature below, and a copy of this authorization is as valid as the original. *Statement required by §164.508(c)(v).* I understand that I have the right to revoke this authorization at any time. The request for revocation must be in writing and sent to: Life and Disability Underwriting, Life and Health Segment, Principal Life Insurance Company and/or Principal National Life Insurance Company, Des Moines, IA 50392-1780. I understand that a revocation is not effective if the Company has relied on the protected health information disclosed to it or has a legal right to contest a claim under an insurance policy or to contest the policy itself. *Statement required by §164.508(c)(2)(i).* Such revocation shall not apply to any use or disclosure of my protected health information specifically allowed without authorization by HIPAA and no action relating to this authorization shall be construed as creating any restriction on the uses that HIPAA allows without my authorization.

I understand that if I refuse to sign this authorization to release my complete medical record, the Company may not be able to process my application for life and/or disability coverage, or if coverage has been issued, may not be able to make any such benefit payments. *Statement required by §164.508(c)(2)(ii).* Upon receipt of your signed authorization, a copy will be provided to you. *Statement required by §164.508(c)(4).* Any alteration of this form will not be accepted.

____ / / __________
Signature of Proposed Insured/Patient or Personal Representative **Date**

____

If you are the personal representative of the proposed insured/patient, describe the scope of your authority to act on this individual's behalf (parent, legal guardian, power of attorney, etc.) on the line above. *Statement required by §164.508(c)(1)(vi).*

Insurance products from the Principal Financial Group®(The Principal®) are issued by Principal National Life Insurance Company (except in New York) and Principal Life Insurance Company.
This completed document is for restricted use only. No part may be copied nor disclosed without prior consent of The Principal®.

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

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

Authorization for Release of Personal Health Information – All States
(Applicable to Individual Life and Disability Insurance Customers)

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

CLIENT COPY

This authorization complies with the HIPAA Privacy Rule and permits health care providers and other covered entities to disclose personal health information.

____ / /
Name of Proposed Insured/Patient (please print) Date of Birth

I authorize any physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, health care provider, health plan, insurer, and/or any other entity subject to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) that has provided treatment, service, or coverage to me within the past 10 years to disclose my entire medical record to the Company, its agents, employees, insurance support organizations, reinsurers, and their representatives. This includes information concerning the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness (excluding psychotherapy notes as defined under HIPAA) and the use of alcohol, drugs, and tobacco. *Statements required by §164.508(c)(1)(ii), (c)(1)(iii).*

I understand my personal health information may be used or disclosed as set forth by this authorization. Protected health information includes information created or received by the Company. Protected health information also includes but is not limited to: hospital records, treatment records/office notes, alcohol or drug abuse treatment, consultation reports, workers' compensation information, diagnosis, prescriptions, test results, vocational testing/counseling information, benefit information, claims information, demographic information, and claims payment information. *Statement required by §164.508(c)(1)(i).*

By my signature, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct any physician, health care professional, hospital, clinic, medical facility, other health care provider or health plan, insurer, or other entity subject to HIPAA to release and disclose my medical record without restriction. I understand that my personal information, including my protected health information disclosed under this authorization, will be incorporated into and made a part of any life and/or disability insurance policy(s) issued by the Company in connection with the application(s) for insurance that I have submitted to the Company. I further understand that the policy(s) will be delivered to the policy owner, which may be my employer or other party. The information included and forming a part of such policy(s), including my protected health information, may be disclosed to the policy owner.

I understand that unless prohibited by state and/or federal law the protected health information is to be disclosed under this authorization so that the Company may: 1) underwrite my application for coverage, make eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage; and 5) conduct other legally permissible activities that relate to any coverage I have, have applied for, or may in the future apply for with the Company. *Statement required by §164.508(c)(1)(iv).*

The following groups of persons employed or working for the Company may use my personal health information which is described above: employees of the underwriting, administration, claim or legal departments and any other personnel of the Company, and its authorized representatives, and business associates that perform functions or services that pertain to any coverage I have, have applied for, or may in the future apply for with the Company. *Statement required by §164.508(c)(1)(ii).*

I understand any information disclosed under this authorization may no longer be covered by the privacy provisions of HIPAA and may be subject to redisclosure. *Statement required by §164.508(c)(2)(iii).*

This authorization shall remain in force for 24 months following the date of my signature below, and a copy of this authorization is as valid as the original. *Statement required by §164.508(c)(v).* I understand that I have the right to revoke this authorization at any time. The request for revocation must be in writing and sent to: Life and Disability Underwriting, Life and Health Segment, Principal Life Insurance Company and/or Principal National Life Insurance Company, Des Moines, IA 50392-1780. I understand that a revocation is not effective if the Company has relied on the protected health information disclosed to it or has a legal right to contest a claim under an insurance policy or to contest the policy itself. *Statement required by §164.508(c)(2)(i).* Such revocation shall not apply to any use or disclosure of my protected health information specifically allowed without authorization by HIPAA and no action relating to this authorization shall be construed as creating any restriction on the uses that HIPAA allows without my authorization.

I understand that if I refuse to sign this authorization to release my complete medical record, the Company may not be able to process my application for life and/or disability coverage, or if coverage has been issued, may not be able to make any such benefit payments. *Statement required by §164.508(c)(2)(ii).* Upon receipt of your signed authorization, a copy will be provided to you. *Statement required by §164.508(c)(4).* Any alteration of this form will not be accepted.

Proposed Insured/Patient Copy – Sign Original / /
Signature of Proposed Insured/Patient or Personal Representative **Date**

____

If you are the personal representative of the proposed insured/patient, describe the scope of your authority to act on this individual's behalf (parent, legal guardian, power of attorney, etc.) on the line above. *Statement required by §164.508(c)(1)(vi).*

Insurance products from the Principal Financial Group®(The Principal®) are issued by Principal National Life Insurance Company (except in New York) and Principal Life Insurance Company.
This completed document is for restricted use only. No part may be copied nor disclosed without prior consent of The Principal®.