



# FIRST PLACE

## PRELIMINARY UNDERWRITING INQUIRY

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

**Corporate Headquarters**

3600 Embassy Parkway  
Suite 100  
Akron, OH 44333  
800.792.6795

**Cleveland Office**

4700 Rockside Road  
Suite 430  
Independence, OH 44131  
800.759.5433

[www.buaweb.com](http://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.

# 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 than 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:

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

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, 3600 Embassy Pkwy, Ste 100, 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.





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

Relationship

X

Description of Authority of Personal Representative

(if applicable)

Signed on (date)

Control Number/Policy Number

Signor name (printed)





**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".

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

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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.

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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).*



**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).*

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