Principal Financial Group

Mailing Address
Des Moines, IA 50392-0001

Principal Life Insurance Company

DI Illustration Request Form (Ind. Life & Health Agent)

113992001

Agent Information: The information requested below is needed for Principal Life Insurance Company records. Please type or print.

Name ______________________ Phone ______________________

Address ______________________ Fax ______________________

Client Information:

Name ______________________ Age ____ Sex: M F

Tobacco Non-Tobacco State of Residence __________ State Written __________

Employment:

Status	Verification Needed with Application	Current Year	Prior Year
Non-owner Employee Salary & Bonus	Form W-2/Current Pay Stub with YTD	$________	$________
Owner Employee C or S Corp.	Form W-2/Current Pay Stub with YTD	$________	$________
Owner Employee C or S Corp.	Form 1120 or Form 1120S	$________	$________
Sole Proprietor	Form 1040 (Schedule C)	$________	$________
Share of Partnership	Form 1040 (Schedule E or K-1)	$________	$________
Pension/Profit Sharing/401(k)	Contribution that would end if you became disabled	$________	$________
Other Earned Income		$________	$________
	TOTAL	$________	$________

Occupation ______________ Number of Employees ________ % of Ownership ________

Exact Duties ____

No. of Years in Occupation ______ Prior Occupation ______________________

Existing Coverage: LTD: 60% 67% 70% / EP: 60/90/180/365 / Maximum of $ __________/ per month

Individual Coverage Requested:

Plan 1 Elimination Period: _____days Benefit Amt.: $ _____ Benefit Period _____

Plan 2 Elimination Period: _____days Benefit Amt.: $ _____ Benefit Period: _____

MEDICAL INFORMATION: ANY HISTORY OF:

High Blood Pressure	Yes	No	Fatigue	Yes	No	Thyroid	Yes	No
Heart Disease	Yes	No	Stress	Yes	No	Cancer	Yes	No
Circulatory Conditions	Yes	No	Anxiety	Yes	No	Tumors	Yes	No
Blood/Protein in Urine	Yes	No	Depression	Yes	No	Cyst	Yes	No
Mental/Nervous Condition	Yes	No	Diabetes	Yes	No	Asthma	Yes	No
Bones/Joints/Skin	Yes	No	Back/Neck	Yes	No	Respiratory	Yes	No

Height ________ Weight ________

Please attach a list of current medications, both prescribed and over-the-counter, along with dosage and frequency. If you check "yes" to any items above, please provide a complete explanation of condition and treatment on a separate sheet of paper.