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

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

Authorization to Disclose Health-Related Information to the Field Office and Financial Professional

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

Proposed Insured Name (Please Print)

I hereby authorize the Company, their employees, officers, and affiliates to disclose any and all medical information ("Information"), which has been collected by the Company in connection with my current request for life insurance or disability insurance to the Field Office and Financial Professional submitting that life insurance or disability insurance request.

I understand the types of information that may be disclosed by the Company pursuant to this Authorization include but are not limited to information regarding test results, my medical care, treatment or surgery and prescription medicines. Additional information that may be disclosed includes information regarding mental health conditions and alcohol or drug abuse information as permitted by law. ***Information regarding HIV test results, AIDS and HIV related conditions will not be disclosed under the terms of this Authorization.*** I understand that information that may have been subject to privacy rules adopted and subsequently amended by the United States Department of Health and Human Services pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) or other laws, once disclosed, may no longer be covered by those rules and may be subject to re-disclosure by the recipient. It is my understanding that the purpose of this authorization is to facilitate submission of this Information by the Field Office and Financial Professional, or their authorized representatives to other insurers to evaluate an application for insurance on my life.

I understand that the Company assumes no liability with respect to any application for insurance to other companies and makes no representation as to the competitiveness or accuracy of the Information. I also understand that the Company will only provide disclosures as permitted by law, and, in its sole discretion, may not provide all Information in its possession. It is my responsibility to disclose any and all requested medical information to any insurance carrier to which I apply for insurance coverage.

I further understand that the Company's privacy policy does not extend to the copy of the Information provided to the Field Office and Financial Professional.

This authorization is effective as of the date it is signed and shall continue for twenty-four (24) months unless otherwise provided by law. I also understand that I may revoke this authorization by providing written notification to the Company at the address provided above, which revocation shall be subject to the rights of the Company, and to the extent the Company has acted in reliance on the authorization prior to notice of revocation.

A copy of this authorization shall be as valid as the original.

My signature below indicates that I have read and understand this authorization.

☐ **I <u>DO</u> hereby authorize the Company to disclose any and all medical information to the Field Office and Financial Professional.**

☐ **I <u>DO NOT</u> authorize the Company to disclose any and all medical information to the Field Office and Financial Professional.**

X _____ _____

Signature of Proposed Insured | Date