Principal® Financial Group

Mailing Address:
Des Moines, IA 50392-0001

Principal Life Insurance Company

Application To Continue Handicapped Child

This form should be completed by the Member to apply for continued coverage beyond the maximum age defined in the policy for the Dependent (other than spouse) named below. Except for age, the Dependent must continue to be a Dependent as defined in the policy. This Dependent must be incapable of self-support as the result of a Developmental Disability or Physical Handicap and must be dependent on the Member for primary support.

Account Number _____

A. Employee Information

Your name (last, first, middle initial) | Date of birth (mo/day/yr) | Social security number

Home address (street) | City | State | ZIP code | Home phone number ( )

B. Dependent Information

Dependent's name (last, first, middle initial) | Date of birth (mo/day/yr) | Dependent's social security number

Was Dependent covered by prior carrier? ☐ yes ☐ no | If yes: date prior coverage ended ___/___/___ | Name and phone number of prior carrier

C. Details About Incapacity: Give complete details so processing is not delayed.

Description of incapacity

How does incapacity interfere with daily life?

When did incapacity start?

D. Schools and Jobs

1. Has this Dependent been going to a school or training facility since reaching age 19 (or age shown in policy)? ☐ yes ☐ no
   If yes, has this Dependent been going Full-Time? ☐ yes ☐ no
2. List schools and facilities attended:

	Is this a custodial care facility? yes	no	Dates attended: from	to
	☐	☐		
	☐	☐		
	☐	☐		

3. What education level has been reached? _____
4. How was this level reached?
   ☐ special education program ☐ regular classes
5. Has this Dependent been working? ☐ yes ☐ no
   (If no, proceed to question #10)
6. If so, where and for how long? _____
7. How many hours per week does this Dependent work? _____
8. Wage earned $_____ per hour.
9. Describe the job duties. _____
10. If this Dependent has not been working, has job placement been suggested? ☐ yes ☐ no
    If no, why not? _____
    If yes, what type of placement? _____
11. What is it about the incapacity that prevents employment?
12. Please provide reason for incapacity. _____

E. Daily Activities

1. Can this Dependent drive a car on his/her own? ☐ yes ☐ no
2. Does this Dependent need help in daily travel to
   school and/or work? ☐ yes ☐ no
   activities outside the house? ☐ yes ☐ no
3. Does this Dependent live at home? ☐ yes ☐ no
   If no, where does this Dependent live? _____
4. If this Dependent's incapacity requires residence at any place other than the home address shown on this form, give name and address of such place and the amount of time spent there.
   Name of residence _____
   Amount of time spent there _____
5. Do you regularly provide more than one-half of the financial support of this child? ☐ yes ☐ no
   If no, explain: _____
6. Is this Dependent claimed as a Dependent by you for federal income tax purposes? ☐ yes ☐ no
   If no, explain: _____
7. Does this Dependent manage his/her own money? ☐ yes ☐ no
8. Does this Dependent have a checking account? ☐ yes ☐ no

F. Member Signature

I represent that to the best of my knowledge and belief all statements and answers made by me on this form are true, complete and correct. They shall be a part of this application for continued coverage under the described group policy. I agree the coverage is subject to approval by Principal Life Insurance Company (The Principal®)at its home office in Des Moines, Iowa; and that continued coverage is subject to written request being made within 31 days after the date the Dependent reaches the maximum age defined in the policy.

I authorize any doctor, health care provider, hospital, clinic, or other medically related facility who has knowledge of the Dependent to give to The Principal any such information. I also understand that any charge for this information is to be paid by me.

Member's signature _____ Date signed _____

G. Employer to Complete

Company name as it appears on your billing

Member's effective date under this group plan / /

Were Member's Dependents covered at that time? ☐ yes ☐ no

If no, when was Dependent coverage effective? / /

H. Statement of Physician About Dependent Named on Reverse Side: This section must be completed by the physician.

Date you first attended this patient

Are you presently seeing this patient for incapacity?

Please furnish the history of the incapacity. Include diagnosis, treatment, results of special studies, present course, prognosis, etc. If the space below does not allow room for sufficient history, please attach the history to this form.

In your opinion, is this patient capable of self-support? ☐ yes ☐ no

If no: what is it about the incapacity that prevents self-support? _____

how long has the incapacity existed? _____

how long may such incapacity be expected to continue? _____

is self-support possible in the future? _____

if so, when? _____

Physician's signature _____ Date signed _____

Physician's printed name _____

Address (street) _____ City _____

State _____ ZIP code _____ Phone number _____