Group Universal Life Statement of Health

INSTRUCTIONS

This form can be filled out online.

Place your cursor in the gray field
Type your information
Hit TAB to accept information entered
Print, sign and turn in

During the initial enrollment period you may purchase 1 – 3 times your wages (up to $300,000) ($10,000 for employees age 70 – 75). For coverage above this amount or after the initial enrollment period, you will need to provide proof of good health.

Your spouse may purchase between $10,000 and $30,000 ($10,000 for spouses between 70 – 75). For coverage above this amount or after the initial enrollment period, your spouse will need to provide proof of good health.

Each person needing to provide proof of good health will need to complete a copy of this form.

STATEMENT OF HEALTH

(To be completed ONLY by those persons requesting coverage in excess of the guaranteed issue amounts or to those persons applying after their enrollment period)

Employee	Spouse
Height ______ ft. ______ inches Weight _______ lbs.	Height ______ ft. ______ inches Weight _______ lbs.

1.	Is any applicant getting or thinking about getting medical treatment, taking any medicine, drugs, pills, shots, etc?	☐ Yes	☐ No

2.	Has any applicant in the past 10 years had or been told he/she has:		
	a. Chest pains, heart trouble, heart attack or heart murmur?	☐ Yes	☐ No
	b. High blood pressure, cancer, or tumors?	☐ Yes	☐ No
	c. Nervous, respiratory, circulatory, digestive, urinary or genital-urinary problems?	☐ Yes	☐ No
	d. Venereal disease or other infectious disease?	☐ Yes	☐ No
	e. Diabetes, pneumonia, or disorder of the lymph system?	☐ Yes	☐ No

3.	In the last 5 years, has any applicant had surgery, been hospitalized or to a doctor, had blood or other diagnostic tests?	☐ Yes	☐ No

THIS SECTION MUST BE FULLY COMPLETED FOR ALL "YES" ANSWERS ABOVE

(If additional space is needed, please attach a separate piece of paper)

Question Number	Name	Nature of Illness or Injury, Treatment, Testing or Medical Attention, etc.	Date		Duration	Diagnosis, Results, Findings or Remaining Effects	Name and Addresses of Physicians or Hospitals
			Mo.	Yr.			

I authorize any medical doctor, health care provider, hospital, clinic or other medical related facility, insurance company, or any other organization, institution or person to give to Principal Mutual Life Insurance Company or its reinsurers any information about me or any named dependents, including physical or mental history and drug or alcohol abuse. A photocopy of this authorization shall be as valid as the original. I understand I may revoke this authorization, by sending written notice to Principal Mutual Life Insurance Company's home office.

I understand that insurance in excess of the amount guaranteed to be issued for myself and dependents will not become effective, notwithstanding the actively at work and period of limited activity provisions, unless medical history is evaluated and satisfactory to Principal Mutual Life Insurance Company.

Signature of Employee		Date	
Signature of Spouse (if spouse coverage elected.)		Date	