Principal® Financial Group

Mailing Address:
Des Moines, Iowa 50392-0002

Principal Life Insurance Company

Risk Appraisal Questionnaire - NY

This questionnaire is intended to help Principal Life Insurance Company underwrite your firm's request for group insurance. This form must be completed by a responsible party of your firm (who knows, or can obtain) the financial history of the firm and health history of the firm's employees and their dependents. That party should complete this form on the basis of that information and to the best of that party's knowledge by:

- Using ballpoint pen.
- Answering all questions.
- Providing details to any "yes" answers.
- Attaching additional pages (signing and dating each) if more space is needed.
- Providing a full disclosure.

Firm name | No. of years in business

SIC code | Nature of business

Has the firm ever filed for bankruptcy, or is the firm now in the process of (or considering) filing for bankruptcy?

no   yes (explain) __________

1. a. Has the firm previously been insured by Principal Life?   yes   no

   b. List all insurance carriers/HMO arrangements for the past 5 years.

Name of Carrier/HMO	Type(s) of Coverage	Period Insured	Reason Moved

   c. Is any coverage continuing with your current carrier?   yes   no

   d. If yes, what type(s) of coverage? __________

   e. What are you looking for in a new carrier? __________

2. Please answer the following questions, providing details to questions answered "yes". Include information on any individual currently insured with your present plan under COBRA or state continuation provisions. Please do not disclose the specific identity of an employee or dependent relative to the medical information requested.

   Provide information regarding dependents only if dependent coverage is requested.

   yes   no

   a. In the last year, has anyone been physically or mentally unable to work or attend school for more than 7 days in total, or had medical bills over $5,000?

   b. Is any employee currently pregnant and/or planning for or scheduled for hospitalization, surgery, medical treatment, therapy, counseling, medical test or examinations or taking any medication?

c. In the last three years, has anyone been treated for and/or been medically diagnosed with any illness or condition related to:

infertility	urinary system	musculoskeletal system	circulatory system/stroke
heart	cancer	endocrine system/diabetes	mental or nervous disorders
lungs	immune system	digestive system	AIDS or ARC (AIDS related complex)
kidneys	nervous system	liver	

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yes **no**

d. Is any employee disabled or not currently actively employed? Is any dependent disabled or not able to perform the normal activities of a person the same age and gender? Are there any dependent children age 19 or over who might be considered developmentally disabled or physically handicapped?

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I hereby represent all information, statements and answers recorded on Page 1 and 2 of this form, and any attachments, are complete and true to the best of my knowledge.

No coverage will be made effective until:

1. a full proposal is made to the group; and
2. application is made by the group to Principal Life; and
3. any information given on this form, the application form, or discovered independently is evaluated and coverage is approved at its home office in Des Moines, Iowa.

An agent or broker cannot change or waive any rates, benefits, or provisions of the policy if issued without the written approval of an officer of Principal Life.

Applies to Accident and Health insurance only: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Employer to Complete:

Benefit administrator's signature	Title	Date
Officer's signature	**Title**	**Date**

Marketing Office to Complete:

Reviewer:	Date called home office	Field underwriting done? ☐ yes ☐ no

Home Office to Complete:

Reviewer:	Date	accept ☐ decline ☐