Application To Continue Disabled Child

Principal Life Insurance Company
Des Moines, IA 50392-0002

Principal®

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 disability and must be dependent on the member for primary support.

If your dental coverage includes Pediatric Dental Essential Benefits, please refer to GP61845 for information about free language services that may be available to you.

Account number _____

A. Employee Information

Your name (last, first, middle initial) | Date of birth | 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 | Dependent's social security number

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

Description of incapacity / reason for 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? ☐ yes ☐ no
   If yes, has this dependent been going full-time? ☐ yes ☐ no
2. What education level has been reached? _____
3. Has this dependent been working? ☐ yes ☐ no (If no, proceed to question #7)
4. Is so, where and for how long? _____
5. How many hours per week does this dependent work? _____
6. Describe the job duties. _____
7. What is it about the incapacity that prevents employment? _____

E. Daily Activities

1. Can this dependent drive a car on his/her own? ☐ yes ☐ no
2. Does this dependent live at home? ☐ yes ☐ no

   If no, where does this dependent live? _____

   Is this a custodial care facility? ☐ yes ☐ no
3. Do you regularly provide more than one-half of the financial support of this child? ☐ yes ☐ no

   If no, explain: _____
4. Is this dependent claimed as a dependent by you for federal income tax purposes? ☐ yes ☐ no

   If no, explain: _____
5. Does this dependent manage his/her own money? ☐ yes ☐ no
6. Does this dependent have a checking account? ☐ yes ☐ no
7. Describe a typical day: _____

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 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 Principal Life any such information. I also understand that any charge for this information is to be paid by me.

The following statement applies only when an applicable state-specific fraud statement does not appear:

Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement, may be guilty of insurance fraud.

Florida: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Maine: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

Member's signature _____ Date signed _____

G. Employer to Complete

Company name as it appears on your billing

Member's effective date under this group

Were member's dependents covered at that time?
☐ yes ☐ no

If not, when was dependent coverage effective?

Print

H. Statement of Physician About Dependent Named on Page 1: This section must be completed by the physician.*

***Please note: Supplemental documents (ie. Social Security documentation, legal guardianship documents, applicable physician notes, etc.) that confirm the questions in this section may be accepted in lieu of physician statement.**

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.

Please provide the Global Assessment of Functioning Scale if applicable. _____

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? ☐ yes ☐ no If so, when? _____

Physician's signature _____ Date signed _____

Physician's printed name _____

Address (street) _____ City _____

State _____ ZIP code _____ Phone number _____

Notice Requirements

Alabama: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

Arizona: Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement, may be guilty of insurance fraud.

Arkansas: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

California: Any false statement made on this form will not bar the right to recovery under the group policy(ies) unless such false statement was made with actual intent to deceive or unless it materially affected either the acceptance of the risk or the hazard assumed by Principal Life.

Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

District of Columbia: Warning: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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.

Louisiana: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

New Jersey: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

New Mexico: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

Notice Requirements (continued)

Ohio: Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Oklahoma: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Pennsylvania: 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 subjects such person to criminal and civil penalties.

Tennessee: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company. Penalties include imprisonment, fines and denial of coverage.

Washington: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

California Fraud Statement Endorsement

Principal Life Insurance Company
Des Moines, IA 50392-0002

Principal®

Principal Life Insurance Company

The Application or Evidence of Insurability form attached to this Endorsement is revised by replacing the existing fraud warning statement with the following:

> **For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.**

All other statements on the Application or Evidence of Insurability form remain in effect.

Executive Vice President,
General Counsel and Secretary

Chairman, President and
Chief Executive Officer