Evidence of Insurability - CA

Principal Life Insurance Company

Des Moines, IA 50392-0002

Principal®

PLEASE USE BLACK INK **PLEASE ENTER DATES AS MM/DD/YYYY**

Account number 1006942

Instructions

1. The Employee Information section should always be completed with the information about the employee.
2. The employee must ALWAYS sign the last page.
3. When coverage is being requested for an eligible dependent(s), this form applies to all persons requesting coverage.
   a. Complete the Eligible Dependent Information section, if applicable.
   b. Complete the Health Information section for you and your eligible dependents, if applicable.
   c. The spouse or state registered domestic partner or nonregistered domestic partner must sign the last page if spouse or state registered domestic partner or nonregistered domestic partner coverage is being requested.
4. After completing and signing this form, make a copy for your records.

If you are applying for critical illness coverage, do you or your eligible dependents have other benefits from an individual or group policy or contract that arranges for or provides medical, hospital, and surgical coverage not designed to supplement other private or governmental plans in force as of the date of this application for critical illness coverage?
NOTE: Critical Illness coverage cannot be issued to a person who does not have such insurance in force.
employee: ☐ yes ☐ no spouse or state registered domestic partner or nonregistered domestic partner: ☐ yes ☐ no

Employee Information

Your name (last, first, middle initial)	Gender ☐ male ☐ female	Social security number	Date of birth

Mailing address (street)

City	State	ZIP code

Email address

Home phone number	Employer name
	City of Redlands

Eligible Dependent Information – Please provide the requested information for the eligible dependents electing coverage.

Name (last, first, middle initial)	Gender	Social security number	Date of birth
Spouse or state registered domestic partner or nonregistered domestic partner	☐ male ☐ female		
	☐ male ☐ female		
	☐ male ☐ female		
	☐ male ☐ female		
	☐ male ☐ female		
	☐ male ☐ female		

If additional dependents, list on separate page. Please sign and date the separate page.

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Health Information 120

To prevent delays give full details to "yes" answers for everyone requesting coverage. If more space is needed, attach a separate page giving full details. Sign and date all those pages.

1. **Employee's height** ___ ft. _____ in. **weight** _____ lbs.

   Spouse's or state registered domestic partner's or nonregistered domestic partner's height ___ ft. _____ in. **weight** _____ lbs.

2. ☐ yes ☐ no — To the best of your knowledge, is any person currently pregnant?

3. ☐ yes ☐ no — **In the past 5 years,** to the best of your knowledge, has any person had surgery, been hospitalized, or visited with a medical professional for the diagnosis or treatment of a specific condition in a medical setting? Provide results of all tests.

4. ☐ yes ☐ no — **In the past 5 years,** to the best of your knowledge, has any person been diagnosed by a medical professional with or received treatment from a medical professional for any of the following (check all that apply)? NOTE: The examples shown for some of the following conditions/diseases are not an all-inclusive list of all applicable variations for that condition/disease.

☐ multiple sclerosis	☐ infertility	☐ stroke	☐ nephritis
☐ colitis/Crohn's disease	☐ alcohol/drug abuse	☐ cirrhosis	☐ irritable bowel (such as irritable bowel disease)
☐ organ or other transplants (such as kidney transplant, liver transplant, cornea transplant)	☐ neurological disease (such as cerebral palsy, Alzheimer's, aneurysm, narcolepsy, Parkinson's disease, trigeminal neuralgia)	☐ cancer/tumor(s) (such as thyroid cancer, breast cancer, skin cancer, prostate cancer)	
☐ psychological/ mental condition (such as anxiety, depression, PTSD, OCS, bipolar disorder, ADD/ADHD, dementia)	☐ ulcer (such as gastric ulcers, esophageal ulcers, duodenal ulcers)	☐ anemia (such as iron deficiency anemia)	

☐ High blood pressure – last reading and date _____ / _____

☐ Diabetes – last HbA1c reading and date _____ / _____

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Health Information (continued) **120**

5. ☐ yes ☐ no **In the past 5 years,** to the best of your knowledge, has any person been diagnosed, treated, or had a study performed by a medical professional for any chronic or progressive disease of any of the following (check all that apply)? NOTE: The examples shown for some of the following conditions/diseases are not an all-inclusive list of all applicable variations for that condition/disease.

☐ liver/hepatitis (such as nonalcoholic fatty liver disease, hepatitis, cirrhosis, hemangioma)	☐ kidney/urinary tract (such as kidney stones, polycystic kidney disease, interstitial cystitis, chronic kidney disease)	☐ muscles/bones/joints (such as arthritis, torn muscles, fractures, joint replacement)	☐ pancreas (such as pancreatitis-acute/chronic/ hereditary, pancreatic carcinoma)
☐ gallbladder (such as biliary colic, biliary disease, gallbladder polyps, gallbladder sludge)	☐ thyroid/gland (such as hypothyroidism, Hashimoto's, thyroid nodules/goiter, pituitary gland disorders)	☐ reproductive system (such as endometriosis, fibroids, polycystic ovary syndrome (PCOS), enlarged prostate or BPH)	☐ asthma/lungs/ respiratory system (such as asthma, bronchitis, cystic fibrosis, COPD, pneumonia, COVID-19)
☐ digestive system (such as GERD, Barrett's Esophagus, celiac disease)	☐ heart or circulatory system (such as coronary artery disease, heart valve disease, heart attack, atrial fibrillation)	☐ skin/eyes/ears/nose/ throat (such as psoriasis, acne, Meniere's disease, shingles, tonsillitis)	☐ spine/back (such as spinal stenosis, degenerative disc disease, herniated disc, scoliosis)
☐ migraines/headaches			

6. ☐ yes ☐ no **In the past 12 months,** to the best of your knowledge, has any person taken or are they currently taking any prescription medication?

7. ☐ yes ☐ no **In the last 5 years,** to the best of your knowledge, has any person had, been treated for or been diagnosed by a medical professional as having AIDS (Acquired Immune Deficiency Syndrome) or ARC (Aids Related Complex)?

California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.

Provide details for all "yes" answers on Page 4.

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Health Information (continued) **120**

Name of person diagnosed	Date diagnosed	Date released from medical care

Diagnosis of illness or condition

If not released, describe current symptoms or problems

Type of treatment (for example surgery or therapy) and names of all current prescription medications including dosage

Frequency of treatment

☐ weekly ☐ monthly ☐ yearly ☐ other

Names and addresses of doctors/physicians, medical practitioners, hospitals or other health care providers

Name of person diagnosed	Date diagnosed	Date released from medical care

Diagnosis of illness or condition

If not released, describe current symptoms or problems

Type of treatment (for example surgery or therapy) and names of all current prescription medications including dosage

Frequency of treatment

☐ weekly ☐ monthly ☐ yearly ☐ other

Names and addresses of doctors/physicians, medical practitioners, hospitals or other health care providers

Name of person diagnosed	Date diagnosed	Date released from medical care

Diagnosis of illness or condition

If not released, describe current symptoms or problems

Type of treatment (for example surgery or therapy) and names of all current prescription medications including dosage

Frequency of treatment

☐ weekly ☐ monthly ☐ yearly ☐ other

Names and addresses of doctors/physicians, medical practitioners, hospitals or other health care providers

Name of person diagnosed	Date diagnosed	Date released from medical care

Diagnosis of illness or condition

If not released, describe current symptoms or problems

Type of treatment (for example surgery or therapy) and names of all current prescription medications including dosage

Frequency of treatment

☐ weekly ☐ monthly ☐ yearly ☐ other

Names and addresses of doctors/physicians, medical practitioners, hospitals or other health care providers

If more space is needed, attach a separate page giving full details. Sign and date all those pages.

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Notice of Information Practices

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In order to properly underwrite and consider your request for coverage, we must collect information to determine if you (and your dependents if also requesting dependent coverage) qualify for insurance with Principal Life Insurance Company. We will do this by having you complete this Evidence of Insurability. In addition, we may contact the following persons/entities besides yourself for personal data about any proposed insured, including (a) spouse or state registered domestic partner or nonregistered domestic partner, (b) employer, (c) medical professionals or institutions, (d) pharmacy benefit managers, and (e) government agencies. The personal data may include age, medical history, job, income, habits and other personal characteristic information. We may also ask that medical exams or other tests be completed.

We will keep your data confidential. Only employees performing business transactions regarding your coverage will see your data. In certain circumstances, we may provide data to (a) government agencies, (b) attending physicians, (c) insurance organizations without identification, (d) the employer, and (e) our reinsurer, if applicable, for the purpose of reporting claims experience or conducting audits.

You or your dependents, if applicable, have certain rights in connection with this request for coverage. Those rights are:

1. to request a copy of any employment or medical information (including physical, mental, drug, or alcohol use history as well as information on the diagnosis and treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases) about you or your dependents contained in Principal Life files (medical information may be disclosed only to you, your dependent, or a medical professional).
2. to correct or amend information in Principal Life files.

Upon written request, Principal Life will furnish to you (or your dependent) information concerning:

1. the nature and scope of employment or medical information in our records, including physical, mental, drug or alcohol use history;
2. the types of disclosures which may be made; and
3. rights of access to the information collected and how such information may be corrected or amended.

We will respond to such written request within 30 days from the date of receipt.

For further information about your file or rights, you may contact: Group Operations, Group Medical Underwriting, Principal Life Insurance Company, 711 High Street, Des Moines, IA 50392-0531.

Authorization, Acknowledgment, and Signatures

- I represent information, statements, and answers on this form, and any attachments, are complete and true to the best of my knowledge. They are a part of this request for coverage under the group policies. I understand that, if approved for disability coverage, Principal Life is not liable for anyone's claim that begins prior to the effective date of coverage.
- I have read, or had read to me, the questions and responses and realize any false statements, omissions or material misrepresentation regarding age or health information could cause coverage, if issued, to be contested.
- **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.**
- If approved for coverage, all policy provisions will apply including, but not limited to, preexisting conditions restriction, the Actively at Work and Period of Limited Activity provisions.
- I understand an agent cannot change or waive any rates, benefits, or provisions of any policy, if issued, without the written approval of an officer of Principal Life.
- I authorize any physician, medical practitioner, health care provider, hospital, clinic or medically related facility, pharmacy benefit manager, insurance company, consumer reporting agency or employer, that has any physical, mental, drug or alcohol use history as well as information on the diagnosis and treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases, regarding me or any dependent, to give to Principal Life, its agents, employees or reinsurers performing business transactions, any such data. I may revoke such authorization at any time by contacting Principal Life at Group Operations, Group Medical Underwriting, Principal Life Insurance Company, 711 High Street, Des Moines, IA 50392-0531.
- I authorize Principal Life to release any such data as required by law. I may revoke such authorization at any time by contacting Principal Life at Group Operations, Group Medical Underwriting, Principal Life Insurance Company, 711 High Street, Des Moines, IA 50392-0531. When signed in connection with any application for, reinstatement of, or request for change in benefits, this form shall be valid for thirty months after the date signed. A photocopy of this form shall be as valid as the original. I understand additional medical records may be requested at the time a claim is filed.

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- I understand the data obtained by use of this authorization will be used by Principal Life for claims administration and to determine eligibility for coverage. This information will not be used for any purposes prohibited by law. I understand that if I refuse to sign this evidence of insurability form, Principal Life may not be able to process my application for life, disability, or critical illness coverage.
- Health information obtained will not be re-disclosed without my authorization unless permitted by law, in which case it may not be protected under federal privacy rules.

Employee's signature	**Date signed**
X	
Spouse's or state registered domestic partner's or nonregistered domestic partner's signature*	**Date signed**
X	

*Spouse's or state registered domestic partner's or nonregistered domestic partner's signature only required if Voluntary Term Life or Critical Illness coverage is elected.

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