Principal®

Principal Life Insurance Company
P.O. Box 14455
Des Moines, IA 50306-3455

Individual Disability Insurance Application – PART A

1. Personal Information about the Proposed Insured

Name (First, Middle, Last)			Gender ☐ Male ☐ Female	Date of Birth / /
Street Address			Social Security Number - -	State of Birth (Country, if other than U.S.)
City	State	Zip	Phone Number ( ) ☐ Cell ☐ Work ☐ Other	
Email Address:				
Occupation/Duties			Driver's License Number	Driver's License State Issued

Have you smoked cigarettes or used a nicotine patch or gum within the past 12 months? ..... ☐ Yes ☐ No
Are you a U.S. citizen or a permanent resident with a Green Card? ☐ Yes ☐ No
If no, submit Confidential Non-US Citizen Questionnaire.

2. Indicate Coverage(s) Applying For

☐ **Disability Income** (Complete Sections 3-7 and Part C)
☐ **Overhead Expense** (Complete Sections 4-7, Part C, and the *Overhead Expense* Application Supplement)
☐ **Disability Buy-Out** (Complete Sections 4-7, Part C, and the *Buy-Out* Application Supplement)
☐ **DI Retirement Security** (Complete Sections 4-7, Part C, and the *DI Retirement Security* Application Supplement)
☐ **Key Person Replacement** (Complete Sections 4-7, Part C, and the *Key Person* Application Supplement)

3. Disability Income

Monthly Benefit Amount: $ _____
Elimination Period: ☐ 30 day ☐ 60 day ☐ 90 day ☐ 180 day ☐ 365 day
Benefit Period: ☐ 2 year ☐ 5 year ☐ to age 65 ☐ to age 67 ☐ to age 70
Your Occupation Period: ☐ 2 year ☐ 5 year ☐ to age 65 ☐ to age 67 ☐ to age 70
SIS Monthly Benefit: $ _____ SIS Benefit Period must equal Base Benefit Period.
SIS Elimination Period: ☐ 30 day ☐ 60 day ☐ 90 day ☐ 180 day ☐ 365 day
Adaptable Income Benefits (AIB) **Note: AIBs program monthly benefits around other in-force coverage**
1st AIB Monthly Benefit: $ _____ from day _____ to day _____
2nd AIB Monthly Benefit: $ _____ from day _____ to day _____
SIS AIB Monthly Benefit: $ _____ from day _____ to day _____

Optional Benefit Riders

☐ Catastrophic Disability Benefit (CDB) Monthly Amount: $ _____
CDB Elimination Period: ☐ 90 day ☐ 180 day ☐ 365 day
CDB Benefit Period: ☐ 2 year ☐ 5 year ☐ to age 65 ☐ to age 67 ☐ to age 70
☐ Cost of Living Adjustment: ☐ 3% max ☐ 6% max
☐ Extended Total Disability Benefit
Aggregate Benefit Factor: ☐ 50 ☐ 75 ☐ 100
☐ Regular Occupation
☐ Residual Disability and Recovery Benefit Rider
☐ Short Term Residual Disability Benefit: ☐ 6 month ☐ 12 month
☐ Transitional Occupation Period: ☐ 2 year ☐ 5 year ☐ to age 65 ☐ to age 67 ☐ to age 70
☐ Other _____

You ***MUST*** select **ONE** of the following:
☐ Benefit Update (BU*) AND Future Benefit Increase (FBI)
☐ Benefit Update (BU*) only
☐ Future Benefit Increase (FBI) only
☐ Neither BU or FBI
*You must apply for 75% of eligible expenses to qualify for Benefit Update

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Individual Disability Insurance Application – PART A

Proposed Insured _____ Policy Number (if known) _____

3. Disability Income (Continued)

Owner (if other than Proposed Insured) – (Please list owner below and sign Part C.)

Name _____ Address _____

City _____ State _____ Zip _____ Owner Taxpayer ID Number _____

Email Address _____

Benefit Recipient (if other than Owner) for Disability Income Only

Name _____ Address _____

City _____ State _____ Zip _____

4. Premium Payer and Method of Payment

a. Premium paid by: ☐ Proposed Insured _____ % ☐ Employer _____ % ☐ Other _____ %
If "Other" please provide:
Name and Address: _____
Date of Birth: _____ Tax ID Number: _____

b. If your employer pays any part of the premium, is it reportable by you as taxable income? ..... ☐ Yes ☐ No

c. Premium Mode: ☐ Annual ☐ Semi Annual* ☐ Quarterly* ☐ Monthly EFT*

d. If multi-life employer billed, premium mode: ☐ Annual ☐ Semi Annual* ☐ Quarterly* ☐ Monthly*

* There is an additional charge for premium payment frequencies other than annual.

5. Other Disability Insurance

Do you have, are you applying for, or will you become eligible for in the next three years (based on a qualifying period of employment), any other Disability Insurance? ..... ☐ Yes ☐ No

If Yes, please list below any Disability Income (listing any Catastrophic or Lifetime Benefits separately), Group Disability, Association, State Disability, Retirement/Pension, Overhead Expense, Disability Buy-Out, Key-person, Salary Continuation or Short Term Contingency Disability Insurance. Also include any policies that include disability benefits provided under Accident or Sickness insurance, Pension, Retirement, Credit Insurance plans, or Loan Protection coverage.

Company	Policy No.	Type of Coverage	Benefit Amt. or % of Income	Elim. Period	Benefit Period	Ind. Pay (I) Emp. Pay (E)	Pending Yes	Pending No	Replacing Yes	Replacing No
						☐ I ☐ E	☐	☐	☐	☐
						☐ I ☐ E	☐	☐	☐	☐
						☐ I ☐ E	☐	☐	☐	☐
						☐ I ☐ E	☐	☐	☐	☐

Replacement: By signing this application, I agree to terminate the insurance policy(s) that I indicated above as being replaced within 60 days of the acceptance of this policy. I understand that if I do not cancel or lapse the insurance policy(s), Principal Life Insurance Company has the right to rescind (terminate as if never issued) any policy issued as a result of this application.

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Individual Disability Insurance Application – PART A

Proposed Insured _____ Policy Number (if known) _____

6. Financial

a. **Unearned Income** – Includes capital gains, interest, dividends, net rental income, pensions, annuities, and alimony. Is unearned income greater than 10% of earned income, or $30,000?..... ☐ Yes ☐ No

If Yes, itemize: _____

b. **Net Worth** – Is net worth, excluding primary residence, greater than $6,000,000? ..... ☐ Yes ☐ No

If Yes, itemize: _____

Tax Year:	Current Year _____	Last Yr. _____	2 Yrs Ago _____
c. **Earned Income** – Income as shown on Federal Income Tax Return:	Current YTD Income	Income Last Yr.	Income 2 Yrs Ago
c1. Owner or Nonowner Employee's salary & bonus, (FormW-2). (less business expenses reported on IRS Form 2106)	$ _____	$ _____	$ _____
c2. Owner-Employee's share of after-tax corp profits or losses (after expenses) (minimum 20% active owner) (Form 1120 or 1120S)	_____	_____	_____
c3. Sole Proprietor net income, after expenses (Form 1040, Schedule C)	_____	_____	_____
c4. Share of Partnership or LLC net income, after expenses (Schedule K-1 or Form 1040, Schedule E)	_____	_____	_____
c5. Pension plan or Profit-Sharing contributions made on your behalf, by a business you own	_____	_____	_____
c6. Total Earned Income: Sum of (c1) thru (c5) for each year	$ _____	$ _____	$ _____

If using Traditional application process, stop here and proceed to Part B (pages 4-7).

7. Medical Question

a. Within the last five years, have you been treated for, or been diagnosed by a member of the medical profession as having a heart condition, chest pain, stroke, back or neck problem, sleep disorder, psychological condition (including, but not limited to, counseling from a mental health or substance abuse provider, and/or psychotherapy), cancer, diabetes, alcohol abuse, or drug dependency? ..... ☐ Yes ☐ No

If Yes, provide details in the Comments below, including dates and healthcare provider's name and address.

b. Current Height _____ Weight _____ Have you lost more than 10 lbs. in the last year?..... ☐ Yes ☐ No

Comments: _____

If using Teleapp, proceed to Part C (page 8).

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Individual Disability Insurance Application – PART C

Proposed Insured _____

Agreement/Authorization to Obtain and Disclose Information.

("Company" means Principal Life Insurance Company)

AGREEMENT: Statements In Application(s): I represent that all statements in this application(s) are true and complete to the best of my knowledge and belief and were correctly recorded before I signed my name below. I understand and agree that the statements in this application(s), including all of its parts, and statements by the Proposed Insured in any medical questionnaire(s) that becomes a part of this application(s), will be the basis of any insurance issued. I understand that misrepresentations could mean denial of an otherwise valid claim and rescission of the policy during the contestable period.

When Coverage Becomes Effective: I understand and agree that the Company shall incur no liability until: (1) a policy issued on this application(s) has been received and accepted by the owner and the first premium paid; and (2) at the time of such delivery and payment, the person to be insured is actually in the state of health and insurability represented in this application(s), medical questionnaire(s), or amendment(s) that becomes a part of this application(s); and (3) the Part D of the Application or the Delivery Receipt form, and any required Amendment and Acceptance or other forms are signed by me and the Proposed Insured (if different) and dated at delivery. If these conditions are met, the policy is deemed effective on the Policy Date stated in the policy. If the application was submitted COD (cash on delivery) or a request for a change in the Policy date is received, the Policy Date may be changed to the date coverage becomes effective and a new Data Page will be sent to the Owner.

Limitation of Authority: I understand and agree that no agent, broker, licensed representative, telephone interviewer, or medical examiner has any authority to determine insurability, or to make, change, or discharge any contract, or to waive any of the Company's rights. The Company's right to truthful and complete answers to all questions on this application(s) and on any medical questionnaire(s) that becomes a part of this application(s) may not be waived. No knowledge of any fact on the part of any agent, broker, licensed representative, telephone interviewer, medical examiner, or other person shall be considered knowledge of the Company unless such fact is stated in the application(s).

☐ This application(s) is Cash on Delivery (C.O.D.); and no Conditional Receipt coverage is provided, or

☐ I have paid $ _____ for Disability Income/$ _____ for Overhead Expense/$ _____ for Disability Buy-Out/$ _____ for Key Person Replacement insurance which is no less than one month's advance premium. If money was paid, I have been given the Conditional Receipt. In return I have read, understand, and agree to its terms, or

If preapproved by Principal Life Insurance Company:

☐ I have signed, dated and submitted to the Company one of the three documents listed below in this box. I have been given the Conditional Receipt. In return I have read, understand, and agree to its terms.

- Payroll Deduction Authorization Form
- Employer Pay Form
- Other form acceptable to the Company

(continued on next page)

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Individual Disability Insurance Application – PART C

Proposed Insured _____

(continued from previous page)

Agreement/Authorization to Obtain and Disclose Information

AUTHORIZATION: I authorize any insurance (or reinsuring) company, consumer reporting agency, governmental agency, insurance agent, broker, licensed representative, or any other organization, institution, or person having personal information (including physical, mental, drug, or alcohol use history) regarding the named Proposed Insured to provide to the Company, its representatives, or reinsurers, any such data. I authorize the Company to conduct a telephone interview in connection with my application(s) for insurance.

I authorize the Medical Information Bureau, Inc. (MIB, Inc.) to furnish data to the Company or its reinsurers. I authorize Principal Life to release any such data to MIB, Inc. or as required by law. Notwithstanding any other provision in this form, the authorization to release data to the MIB, Inc. shall survive the termination of this form to the extent necessary to confirm, correct, or update previously supplied data to the MIB, Inc. Data released may include results of my medical examination or tests requested by the Company. I understand that the data obtained by use of this authorization will be used by the Company to determine eligibility for insurance.

I have received a copy of the "Notice of Insurance Information Practices," which includes notice required by any Fair Credit Reporting Act. It also describes MIB, Inc. I agree that this authorization shall be valid for 24 months from the earlier of: (1) the date of this application(s), or (2) the date of my policy, unless an earlier date is required by applicable law in the state where the policy is delivered or issued for delivery . I may revoke this authorization for information not then obtained. Such revocation must be in writing. It will not be effective until received at the Company's Home Office. I agree that a photocopy of this authorization is as valid as the original. I have received a copy of this authorization.

Warning: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

SIGNATURES, City, State, Date and printed name of Agent/Broker/Licensed Representative are required.

Signature of Proposed Insured **X**	Signed at: City	State	Date / /
Disability Income; Signature of Owner (If other than Proposed Insured) **X**	Title (If Corporation, Officer other than Proposed Insured)		Date / /
Overhead Expense; Signature of Owner (If other than Proposed Insured) **X**	Title (If Corporation, Officer other than Proposed Insured)		Date / /
Disability Buy-Out; Signature of Owner **X**	Title (If Corporation, Officer other than Proposed Insured)		Date / /
Key Person Replacement; Signature of Owner **X**	Title (Officer other than Proposed Insured)		Date / /
Signature of Agent/Broker/Licensed Representative **X**	License Number		Date / /
Printed name of Agent/Broker/Licensed Representative **X**			

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Individual Disability Insurance Application – PART C

Agreement/Authorization to Obtain and Disclose Information.

("Company" means Principal Life Insurance Company)

AGREEMENT: Statements In Application(s): I represent that all statements in this application(s) are true and complete to the best of my knowledge and belief and were correctly recorded before I signed my name below. I understand and agree that the statements in this application(s), including all of its parts, and statements by the Proposed Insured in any medical questionnaire(s) that becomes a part of this application(s), will be the basis of any insurance issued. I understand that misrepresentations could mean denial of an otherwise valid claim and rescission of the policy during the contestable period.

When Coverage Becomes Effective: I understand and agree that the Company shall incur no liability until: (1) a policy issued on this application(s) has been received and accepted by the owner and the first premium paid; and (2) at the time of such delivery and payment, the person to be insured is actually in the state of health and insurability represented in this application(s), medical questionnaire(s), or amendment(s) that becomes a part of this application(s); and (3) the Part D of the Application or the Delivery Receipt form, and any required Amendment and Acceptance or other forms are signed by me and the Proposed Insured (if different) and dated at delivery. If these conditions are met, the policy is deemed effective on the Policy Date stated in the policy. If the application was submitted COD (cash on delivery) or a request for a change in the Policy date is received, the Policy Date may be changed to the date coverage becomes effective and a new Data Page will be sent to the Owner.

Limitation of Authority: I understand and agree that no agent, broker, licensed representative, telephone interviewer, or medical examiner has any authority to determine insurability, or to make, change, or discharge any contract, or to waive any of the Company's rights. The Company's right to truthful and complete answers to all questions on this application(s) and on any medical questionnaire(s) that becomes a part of this application(s) may not be waived. No knowledge of any fact on the part of any agent, broker, licensed representative, telephone interviewer, medical examiner, or other person shall be considered knowledge of the Company unless such fact is stated in the application(s).

☐ This application(s) is Cash on Delivery (C.O.D.); and no Conditional Receipt coverage is provided, or

☐ I have paid $ _____ for Disability Income/$ _____ for Overhead Expense/$ _____ for Disability Buy-Out/$ _____ for Key Person Replacement insurance which is no less than one month's advance premium. If money was paid, I have been given the Conditional Receipt. In return I have read, understand, and agree to its terms, or

If preapproved by Principal Life Insurance Company:

☐ I have signed, dated and submitted to the Company one of the three documents listed below in this box. I have been given the Conditional Receipt. In return I have read, understand, and agree to its terms.

- Payroll Deduction Authorization Form
- Employer Pay Form
- Other form acceptable to the Company

AUTHORIZATION: I authorize any insurance (or reinsuring) company, consumer reporting agency, governmental agency, insurance agent, broker, licensed representative, or any other organization, institution, or person having personal information (including physical, mental, drug, or alcohol use history) regarding the named Proposed Insured to provide to the Company, its representatives, or reinsurers, any such data. I authorize the Company to conduct a telephone interview in connection with my application(s) for insurance.

I authorize the Medical Information Bureau, Inc. (MIB, Inc.) to furnish data to the Company or its reinsurers. I authorize Principal Life to release any such data to MIB, Inc. or as required by law. Notwithstanding any other provision in this form, the authorization to release data to the MIB, Inc. shall survive the termination of this form to the extent necessary to confirm, correct, or update previously supplied data to the MIB, Inc. Data released may include results of my medical examination or tests requested by the Company. I understand that the data obtained by use of this authorization will be used by the Company to determine eligibility for insurance.

I have received a copy of the "Notice of Insurance Information Practices," which includes notice required by any Fair Credit Reporting Act. It also describes MIB, Inc. I agree that this authorization shall be valid for 24 months from the earlier of: (1) the date of this application(s), or (2) the date of my policy, unless an earlier date is required by applicable law in the state where the policy is delivered or issued for delivery. I may revoke this authorization for information not then obtained. Such revocation must be in writing. It will not be effective until received at the Company's Home Office. I agree that a photocopy of this authorization is as valid as the original. I have received a copy of this authorization.

Warning: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

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Individual Disability Insurance Conditional Receipt

(In this Conditional Receipt (Receipt), "we", "us", "our", or "the Company" is Principal Life Insurance Company.)

Name of Proposed Insured

Advance payment of: (Disability Income) $ _____ (Overhead Expense) $ _____ (Disability Buy-Out) $ _____ (Key Person) $ _____

has been received this date as a premium deposit with the application(s) bearing the same date as this Receipt.

Agent/Broker/Licensed Representative

Date of Receipt ___ / ___ / _____

Authority:

This Receipt is not a "binder." No agent, broker, licensed representative, medical examiner, or telephone interviewer may accept risks, determine insurability, or bind the Company in any way. No agent, broker, or licensed representative may waive or change any terms of the Receipt, or of the policy(ies) applied for, or any other rights of the Company.

The agent, broker, or licensed representative has **NO AUTHORITY** to accept any premium or to issue this Receipt if it is apparent that any **Condition Precedent** to coverage under this Receipt is not or cannot be satisfied. **This Conditional Receipt shall be ineffective if issued without authority. Only the Home Office, and not the agent, broker, or licensed representative, has authority to modify any provisions of this Receipt.**

Insurance Provided:

If all of the **Conditions Precedent** set forth in this Receipt are fulfilled exactly, insurance under this Receipt takes effect on the **Start Date**. The Start Date is the date upon which all of our initial application(s) requirements are completed. Our initial application(s) requirements consist of full completion and signing of the application(s) (Parts A and C, if using the telephone application(s) process; Parts A, B, & C, if using the paper application(s) process) and all necessary supplements, and any medical exams and tests required by our published rules.

The insurance provided by this Receipt shall be the lesser of the amount applied for on this application(s) or the amount set forth in the **LIMITATIONS** section of this Receipt, subject to all the **LIMITATIONS** set forth in this Receipt. Any insurance provided by this Receipt ends on the **Stop Date**, which is the **earliest** of:

(a) 75 days after the Start Date;

(b) the date we mail the premium payer a premium refund and the proposed owner a notice that we will not consider the application(s) on a prepaid basis;

(c) the date we mail the premium payer a premium refund and the proposed owner a notice that no policy(ies) will be issued on the application(s);

(d) the date a policy(ies) is presented to the proposed owner (whether or not accepted by the proposed owner).

This Receipt does not commit us to issue any policy(ies). However, in determining whether to issue a policy(ies) and on what terms, we will consider no changes in the Proposed Insured's health or insurability occurring between the Start Date and the Stop Date. We have until the actual delivery of the policy(ies) to make this determination. If an event giving rise to a claim occurs at any time before physical delivery and acceptance of a policy(ies) by the owner, the claim will be considered solely under this Receipt even if a policy(ies) is issued. If any provision of this Receipt is unenforceable under state law, all other terms and conditions shall continue in full force and effect.

Conditions Precedent if a premium deposit is submitted with this application(s):

All the following conditions must be fulfilled exactly. Otherwise there is NO insurance under this Receipt and the Receipt is void:

1. On the Start Date, the Proposed Insured must be insurable, as determined by our underwriters under our underwriting guidelines then in effect. If a condition affecting such insurability existed in fact on the Start Date, it shall be considered in the determination of insurability.
2. All statements of material fact are included in Part(s) A, B, and C of this application(s), any supplemental form(s), and medical questionnaire(s) that become part of the policy(ies) and such statements are correct, true, and complete.
3. The premium deposit must be at least one full month's premium for each policy(ies) applied for.
4. The premium deposit must be paid at the time this application(s) is signed, and this Receipt must be issued at the same time.
5. The premium deposit must be received in our Home Office and must be honored on first presentation for payment.

--CONTINUED--

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Conditions Precedent if no premium deposit is submitted with this application(s):

All the following conditions must be fulfilled exactly. Otherwise there is NO insurance under this Receipt and the Receipt is void:

1. On the Start Date, the Proposed Insured must be insurable, as determined by our underwriters under our underwriting guidelines then in effect. If a condition affecting such insurability existed in fact on the Start Date, it shall be considered in the determination of insurability.
2. All statements of material fact are included in Part(s) A, B, and C of this application(s), any supplemental form(s), and medical questionnaire(s) that become part of the policy(ies) and such statements are correct, true, and complete.
3. Documentation authorizing payment of premiums, which is acceptable to the Company, must be signed, dated, and submitted with this application(s), and this Receipt must be issued at the same time.
4. Documentation authorizing payment of premiums and acceptable to the Company must be received in our Home Office.

Limitations:

1. Except as limited by this Receipt, our liability is governed by the terms of the policy(ies) including but not limited to all policy(ies) riders and endorsements.
2. No benefit is payable under this Receipt and this Receipt is void, if there is any incorrect, untrue, incomplete, or omitted statement of material fact in Part A, B, or C of the application(s), any supplemental form, or medical questionnaire(s) that becomes a part of the policy(ies). No knowledge of any fact on the part of any agent, broker, licensed representative, medical examiner, telephone interviewer, or other person shall be considered knowledge of the Company unless such fact is stated in the application(s).
3. **Disability Income, Catastrophic Disability Benefit, Overhead Expense, Business Loan Protection Benefit, Disability Buy-Out or Key Person Replacement –** For any claim that occurs at any time after the Start Date and before physical delivery and acceptance of a policy(ies) by the owner, any Disability Income, Catastrophic Disability Benefit, Overhead Expense, Business Loan Protection Benefit, Disability Buy-Out or Key Person maximum benefit payable will be the lesser of:
    - The amount of benefits applied for in the application(s);
    - The amount of benefits that would be offered subject to our then current underwriting guidelines and practices; or
    - $5,000 per month (Disability Benefit and Social Insurance Substitute Benefit); $5,000 per month (Overhead Expense Benefit); $5,000 per month (Business Loan Protection Benefit); $2,500 per month (Catastrophic Disability Benefit); $2,500 per month and $200,000 Lump Sum (Key Person Replacement Benefit); $500,000 (Disability Buy-Out Maximum Aggregate Benefit).

    The coverage available under the Conditional Receipt, such as the elimination period, the benefit period, the policy(ies), policy(ies) riders, and riders related to exclusions, limitations, modifications, or enhancements of coverage will be based on what we would have approved or offered to you subject to our then current underwriting guidelines and practices.

Premiums:

If a policy(ies) is issued from this application(s) bearing the same date as this Receipt, and the policy(ies) is accepted by the proposed owner, we will apply the premium deposit to the first premium due for such policy(ies). If no policy(ies) is put in force but a benefit is paid under this Receipt, we will keep the earned portion of the premium deposit and refund the balance, if any, to the premium payer. If no policy(ies) is put in force and no benefit is paid or if a policy(ies) is issued differently then applied for that results in a premium refund, the premium deposit or excess premium will be refunded to the premium payer. If this Receipt is issued for more than one type of insurance, the provisions of this paragraph shall apply separately with respect to each type.

ALL PREMIUM CHECKS MUST BE MADE PAYABLE TO PRINCIPAL LIFE INSURANCE COMPANY – DO NOT MAKE CHECKS PAYABLE TO THE AGENT/BROKER/LICENSED REP. OR LEAVE THE PAYEE BLANK.

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Individual Key Person Replacement Application Supplement

1. Personal Information

Proposed Insured: _____ Date of Birth _____

2. Benefits

☐ Lump Sum benefit only (Complete Lump Sum section below)

☐ Combination method (Complete both Lump Sum and Monthly Payment sections below)

Lump Sum: Benefit Amount $ _____

Elimination Period ☐ 180 day ☐ 365 day ☐ 730 day

Monthly Payment: Benefit Amount $ _____

Elimination Period (must be less than lump sum elimination) ☐ 90 day ☐ 180 day

3. Owner (Must be Business) – (Please list owner and have owner sign this form and Part C).

Name (Owner) _____ Address _____

City _____ State _____ Zip _____ Owner Taxpayer ID Number _____

Email Address: _____

4. Key Employee Information

a. Occupational Duties: (Please be specific) _____

b. What duties does this Key Person perform that cannot be performed by another employee? _____

c. What financial loss would the firm suffer if Key Person were disabled and unable to work? _____

d. How long has the Key Person been employed with the firm? _____

e. Is the Key Person an owner in the firm? ☐ Yes ☐ No

If Yes, ownership % _____ Length of ownership _____

f. Is the Key Person related to any of the business owners? ☐ Yes ☐ No

If yes, please explain relationship _____

g. Is there any other existing or pending insurance coverage on the Key Person in which the firm will receive the insurance benefits? ☐ Yes ☐ No

If Yes, advise type and amount of insurance and the name of the insuring company: _____

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Individual Key Person Replacement Application Supplement

Proposed Insured _____ Policy Number (if known) _____

5. Employer Information

a. Firm Name: _____

b. Type of business: _____

c. Number of employees: _____Full-time _____Part-time _____Contracted

d. How long in business? _____

e. **Net Profit/Loss Information**:

	Current Year	Last year	2 years ago
Tax Year			
Net Profit/loss of the firm			

f. Does the business have a website? ☐ Yes ☐ No

If Yes, provide website address: _____

g. Are there other key persons in the firm? ☐ Yes ☐ No If Yes, how many? _____

h. Are the others to be insured? ☐ Yes ☐ No

i. How many other employees have the same job duties as the Key Person / Proposed Insured? _____

_____

Warning: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

I represent that all the above statements in this application are true and complete to the best of my knowledge and belief. I understand that the statements in this application are a part of any insurance issued.

SIGNATURES (Please do not print name below. **Signatures are required.**)

Proposed Insured **X**	Signed at: City	State	Date / /
Owner **X**	Title (Officer other than Proposed Insured)		Date / /
Witness (Agent/Broker/Licensed Rep.) **X**			Date / /

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