Principal®
Principal Life Insurance Company
Principal National Life Insurance Company
Members of Principal Financial Group®

P.O. Box 10431
Des Moines, IA 50306-0431

Medical Questionnaire

Only one company is the issuer and responsible for obligations of any given policy and is hereinafter referred to as "the Company".

Print full name of Proposed Insured	Date of Birth (Month/Day/Year)

	Yes	No
1. In the last ten years, have you been treated for or been diagnosed by a member of the medical profession as having:		
a. high blood pressure, heart attack, chest pain, heart murmur, irregular heart beat, stroke, anemia, or any other disease or disorder of the heart or blood vessels?	☐	☐
b. cancer or a tumor, cyst or growth?	☐	☐
c. asthma, bronchitis, emphysema, sleep apnea, tuberculosis or any other disease or disorder of the lungs or respiratory system?	☐	☐
d. seizure, paralysis, headaches, multiple sclerosis or any other disease or disorder of the brain or nervous system?	☐	☐
e. chronic fatigue, stress, depression, anxiety or any other emotional or psychological disorder?	☐	☐
f. hepatitis, colitis, ulcer, cirrhosis, irritable bowel or any other disease or disorder of the liver, gallbladder, pancreas or digestive tract?	☐	☐
g. diabetes, borderline diabetes, sugar in the urine, thyroid disorder or any other disease or disorder of the glandular system?	☐	☐
h. kidney stones, nephritis, any blood or protein in the urine, sexually transmitted disease, prostate disorder, breast disorder or any other disease or disorder of the urinary or reproductive system?	☐	☐
i. back or neck pain, disc problems, spinal sprain or strain, sciatica, arthritis, carpal tunnel syndrome, fibromyalgia, or any other disease or disorder of the bones, joints, or muscles?	☐	☐
j. any disease or disorder of the eyes, ears, nose, throat or skin?	☐	☐
k. any disease or disorder of the immune system, except those related to the Human Immunodeficiency Virus (AIDS virus)?	☐	☐
2. (DI Only) Are you currently pregnant or have you been diagnosed by a member of the medical profession as having complications of pregnancy in the last ten years?	☐	☐
3. In the last ten years, have you been diagnosed by a member of the medical profession or tested positive for Human Immunodeficiency Virus (AIDS virus) or Acquired Immunodeficiency Syndrome (AIDS)?	☐	☐
4. In the last five years:		
a. have you had any medical tests (excluding tests for HIV (AIDS Virus), hospitalization, illness or injury not provided in response to a previous question?	☐	☐
b. have you consulted a doctor, chiropractor, psychiatrist, psychologist, counselor, therapist or other healthcare provider not provided in response to a previous question?	☐	☐
5. Are you taking or have you been advised by a member of the medical profession in the last five years to take any medication or supplement (including medicinal marijuana) or treatment not provided in response to a previous question?	☐	☐
6. Have you lost more than 10 lbs. in the last year? If yes, ____ lbs./kgs. Provide details of weight loss. _____	☐	☐
7. a. Has either of your natural parents lived to at least age 60?	☐	☐
b. Has any of your natural parents or siblings been diagnosed or treated by a member of the medical profession for diabetes, cancer, stroke or heart disease? If yes, provide details (i.e., relationship, type of disease, age diagnosed, current age or age at death)	☐	☐
8. Have you ever had any life, health or disability insurance rated, modified or declined? (If yes, provide details)	☐	☐

DETAILS TO QUESTIONS 1-8

For "yes" answers to questions 1-6 include dates, details, diagnosis, types and results of treatment, healthcare provider's full name and address. (if additional space needed, attach a separate page that is completed, witnessed, signed, and dated)

Quest. #	

Medical Questionnaire, continued

9. Who is your Primary Physician or medical facility you have seen in the last five years? ☐ None

a. Name Phone Number

Street City State Zip

b. Date last seen, reason and details

I have read the statements and answers recorded above; they are to the best of my knowledge and belief true, complete and correctly recorded. I agree that they will become part of my application and any policy issued on it.

Signature of Proposed Insured	Date	Signature of Witness/Title
X		**X**

PHYSICAL MEASUREMENTS RECORDED BY EXAMINER

10. a. Height (in Shoes) feet _____ in. _____ ; or cm _____
b. Weight (Clothed) pounds _____ ; or kg _____
c. Did you weigh? ☐ Yes ☐ No Did you measure? ☐ Yes ☐ No
d. Chest (Full Inspiration) in./cm. _____
Chest (Forced Expiration) in./cm. _____
Abdomen, at Umbilcus in./cm. _____

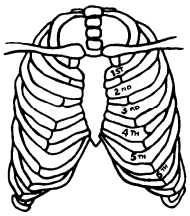
11. Blood Pressure in sitting position:

	First Reading	Second Reading	Third Reading
Systolic/ Diastolic			

12. Pulse:

	At Rest
Rate	
Irregularities per min.	

13. Heart: is there any:
Enlargement ☐ Yes ☐ No Dyspnea ☐ Yes ☐ No
Murmur(s) ☐ Yes ☐ No Edema ☐ Yes ☐ No
(describe below)
Location
☐ Constant Indicate:
☐ Inconstant
☐ Transmitted Apex by X
☐ Localized
☐ Systolic Murmur area by ◌
☐ Diastolic Point of greatest
☐ Soft (Gr. 1-2) intensity by ○
☐ Mod. (Gr. 3-4) Transmission by →
☐ Loud (Gr. 5-6)



14. Is there any abnormality of the following (circle applicable items and give details) on examination:

	Yes	No
(a) Eyes, ears, nose, mouth, pharynx? (If vision or hearing markedly impaired, indicate degree and correction.)	☐	☐
(b) Skin (incl. scars); lymph nodes; varicose veins; peripheral arteries?	☐	☐
(c) Nervous system (include reflexes, gait, paralysis)?	☐	☐
(d) Respiratory system?	☐	☐
(e) Abdomen (include scars)?	☐	☐
(f) Genitourinary system (include prostate)?	☐	☐
(g) Endocrine system (include thyroid and breasts)?	☐	☐
(h) Musculoskeletal system (include spine, joints, amputations, deformities)?	☐	☐
15. (a) Are there any hernias?	☐	☐
(b) Any hemorrhoids?	☐	☐
16. Are you aware of additional medical history?	☐	☐

Give details to "Yes" answers:

Name of agent soliciting application: _____

Examination made at: ☐ Examiner's Office ☐ Applicant's Home ☐ Other _____

Examiner (print name) _____ M.D./D.O./Para Med.

Exam Company Name _____

Exam Company Address _____

Signature of Examiner **X** _____

Send exam to Home Office only.

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Print full name of Proposed Insured	Date of Birth (Month/Day/Year)

Quest. #	Include dates and details as requested.

Signature of Proposed Insured	Date	Signature of Witness/Title
X		**X**