



Mailing Address: Des Moines, Iowa 50392-0002

Principal Life Insurance Company

Risk Appraisal Questionnaire - NJ

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 arrangements for the past 5 years.

Table with 4 columns: Name of Carrier, 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.

a. In the last year, has anyone been physically or mentally unable to work or attend school for more than 7 days in total? yes no

b. Is anyone 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 | |
| kidneys | nervous system | liver | |

d. Is any employee disabled or not currently actively employed? **yes no**

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.

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

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? <input type="checkbox"/> yes <input type="checkbox"/> no

Home Office to Complete:

Reviewer:	Date	accept <input type="checkbox"/> decline <input type="checkbox"/>