

Personal information form

For pre-screening, illustrations, or application needs



Basic information

Name: _____ Date of birth: _____ Gender: _____
 Permanent address: _____ City: _____ State: _____ Zip: _____
 Phone number: _____ Email address: _____

Occupation

Occupation title: _____ Years in position: _____
 Amount of physical work in current position: Low (0-30%) Moderate (31-60%) High (61-100%)
 Explain job duties: _____

Salary/bonus income (prior year): \$ _____ Other income: \$ _____
 Unearned income: \$ _____ Work from home: No Yes
 Self-employed: No Yes
 If yes: How long: _____ Number of full-time (30+ hrs/wk) employees: _____
 Percent of ownership: _____

Other coverage

Do you have other disability coverage: No Yes If yes, provide details:

Benefit amount	Maximum benefit	Elimination period	Benefit period	Paid by (your employer or you)

Health information

Tobacco use: No Yes If yes, please describe: _____
 Height: _____ Weight: _____

Are you in the military with active deployment papers?	<input type="radio"/> No <input type="radio"/> Yes	<p>If you answered "No" to both questions, continue to the next page.</p> <p>If you answered "Yes" to either question, please don't continue. Instead, contact your financial professional to discuss your options.</p>
Do you have lupus, multiple sclerosis or type 1 diabetes?	<input type="radio"/> No <input type="radio"/> Yes	

Do you have a history or current diagnosis of:

- | | | |
|--|---|--|
| <input type="checkbox"/> Asthma/respiratory conditions | <input type="checkbox"/> Crohn's disease/ulcerative colitis | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Back/neck conditions | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Mental/nervous conditions
(anxiety/depression) |
| <input type="checkbox"/> Blood/protein in urine | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Stress |
| <input type="checkbox"/> Bones/joint conditions | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Cancer/tumor | <input type="checkbox"/> Heart disease | |
| <input type="checkbox"/> Circulatory conditions | | |

Please describe any conditions selected above: _____

List any current medications: _____

Are you pending any surgery? No Yes If yes, provide details: _____

Do you participate in any activities that could be considered dangerous? No Yes
If yes, please describe: _____

Do you have any citations on your driving record? No Yes
If yes, please describe: _____

Have you filed for bankruptcy or had a bankruptcy discharged in the last two years? No Yes

Additional protection needs

- DI Retirement Security (income must be at least \$76K).** Helps you continue to save for retirement in the event of a disability.
- Overhead Expense.** Reimburses an owner for business expenses during a disability.
- Business Loan Protection.*** Covers loans for business-related expenses.
- Disability Buy-Out.*** Funds a buy-sell agreement to buy out a disabled business owner.
- Key Person Replacement.*** Provides benefits to a business if a key employee becomes disabled.

Financial professional contact information

Name: _____ Phone number: _____

Email address: _____

*Not available in all states. Go to principal.com/distateapprovals for more information.

principal.com

Not FDIC or NCUA insured
May lose value • Not a deposit • No bank or credit union guarantee
Not insured by any Federal government agency