



Mailing Address:
P.O. Box 4934
Grand Island, NE 68803

Principal Life
Insurance Company

120
**Authorization for Release
of Health Information for
Underwriting Purposes –
All States**

I authorize that any/all health statements that I have signed within the 90-day period prior to the date this form is signed can be released to Principal Life Insurance Company for the purpose of underwriting the group insurance benefits provided by the employer named below.

I understand that if I refuse to provide this authorization, Principal Life may not make an underwriting determination, and I will not be considered for coverage with Principal Life.

I have read and I understand this authorization.

Name of employee Date of birth

Employer name

Signature of employee Date

A copy of this signed, completed authorization form is available to you upon request.