The General Description and Benefit Example in this section are for informational purposes only.
Refer to your employee booklet for your coverage amounts.

General Description

An accelerated benefit is an advance (before death) payment of a part of your member life insurance benefit. To qualify for an accelerated benefit, you must:

– be insured for a member life insurance benefit of at least the amount indicated in your benefit booklet (typically $10,000 - $20,000); and
– be terminally ill (expected to die within the time period indicated in your benefit booklet; typically 12-24 months); and
– send proof satisfactory to us of your terminal illness; and
– provide a release from the assignee if any part of your member life insurance benefit has been assigned.

If you qualify, we will pay you any amount you request; except that:

– only one accelerated benefit payment will be made during your lifetime; and
– your request for payment must be at least the amount indicated in your benefit booklet (typically $5,000 or $10,000); and
– we will not pay you more than the amount indicated in your booklet (typically 50% – 75% up to a maximum amount specified in your policy and benefit booklet).

If an accelerated benefit is paid, the member life insurance benefit otherwise payable to your beneficiary upon your death will be reduced by the sum of:

– the accelerated payment ; plus
– accumulated interest charges.

Accumulated interest charges will be the sum of interest charged for each day of the period from the date of your accelerated benefit payment to the date of your death but not more than two years (or as indicated in your life policy and benefit booklet). This interest will be calculated by applying a daily rate (equivalent to 8% per year) to the amount of your accelerated benefit payment.

Benefit Example

– Member life insurance benefit amount	$ 100,000
– Accelerated benefit amount requested	$ 50,000
– Accelerated benefit paid on August 15	
– Member dies on November 15 (92 days after payment)	
– Accumulated interest charges ($50,000 x .08) x (92/365 days)	$ 1,008
– Payment to beneficiary ($100,000 - $50,000 - $1,008)	$ 48,992

Tax Consequences

Accelerated benefit payments from this policy may qualify for special tax status if, according to federal definitions, the insured qualifies as terminally ill, or qualifies as chronically ill and uses the accelerated benefit to pay for costs incurred by the insured during the chronic illness. However, if the accelerated benefit is based on “medical conditions” and not terminal or chronic illness as defined in the federal tax code, the benefits may be taxable. We recommend that you contact a tax advisor when making tax-related decisions about electing to receive and use benefits from an accelerated benefit product.

Effect on Government Benefits

Receipt of an accelerated benefit might adversely affect your eligibility for Medicaid or other government benefits or entitlements.

Principal Financial Group

Mailing Address:
Des Moines, IA 50392-0002

Principal Life Insurance Company

Accelerated Benefit Claim Information

EMPLOYER: Please return to Principal Life Insurance Company

Statement of Employer

Employee's name | I.D. number | Unit/Division number

Benefit plan | Date of employment | Effective date of plan | Effective date of last change

Percentage of premium paid by employer | Amount of member life insurance coverage

Has the employee ceased working? ☐ yes ☐ no | Date employee last worked? | Is employee's coverage still in force? ☐ yes ☐ no | If no, give date of termination

Employee's salary monthly $ | Weekly? $ | Effective date of salary | Number of hours worked/week

Employer name | Employer account number

Signature of planholder ▶ | Title | Telephone number | Date

Instructions to Employee

1. This form is to be filed if you are terminally ill and you elect an Accelerated Benefit.
2. This form should be completed in its entirety by the employer, the employee and attending physician.
3. To avoid delay in benefits, please answer all questions completely and legibly.
4. If you have any additional information you feel would help in the review of this claim, please attach to this form.
5. Be sure to complete and sign the attached authorization for the release of information (page 6) and return it with the other sections of this form.

Statement of Employee (Please review the Notice Requirements on Page 5 prior to signing).

Your name _____ Your occupation _____

Telephone number _____ Date of birth _____ Social security number _____

Amount of accelerated benefit requested? _____

Have you been hospital confined? ☐ yes ☐ no If yes, when? from _____ to _____

Name of hospital _____ Address _____

Name and address of your doctors during the past year	Sickness or injury	Date consulted

These statements are true and complete to the best of my knowledge | Date

Signature of employee

Address of employee: Street | City | State | ZIP

If this a new address? ☐ yes ☐ no

Florida: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Maine: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

Statement of Assignee

I agree and consent to this request for accelerated benefit payment. I understand that this payment may reduce the amount of benefit that would otherwise be payable to me upon the employee's death.

Signature of assignee | Date

Attending Physician's Statement

1. **To Physician**

   The patient is requesting an advance payment of life insurance. Your statement is needed to determine patient's eligibility.

2. **History**

   (a) When did symptoms first appear or accident happen? mo._____ day _____ year _____

   (b) Date patient informed of diagnosis? mo._____ day _____ year _____

   (c) Has patient ever had same or similar condition? ☐ yes ☐ no if "yes" state when and describe

3. **Diagnosis and Prognosis**

   (a) Diagnosis (including any complications):

   (b) Subjective symptoms:

   (c) Objective findings (including current X-rays, EKG'S, Laboratory Data and any clinical findings):

   (d) Is the patient competent to endorse checks and direct the use of proceeds? ☐ yes ☐ no

   (e) Is patient's condition terminal? ☐ yes ☐ no

   (f) If yes, within _____ months

   (g) Other comments:

4. **Dates of Treatment**

   (a) Date of first visit? mo._____ day _____ year _____

   (b) Date of last visit? mo._____ day _____ year _____

   (c) Frequency? ☐ weekly ☐ monthly ☐ other (specify) _____

5. **Nature of Treatment (including surgery and medications prescribed, if any)**

Print physician's name	Degree	Specialty	Telephone

Street address	City	State or Province	ZIP code	Tax identification number

I certify that the above information is complete and accurate to the best of my knowledge.

Physician's signature _____ Date _____

Notice Requirements

Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement, may be guilty of insurance fraud.

Alabama: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

Arizona: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

Arkansas: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

California: For your protection California law requires the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

District of Columbia: Warning: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Louisiana: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Maryland: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

New Mexico: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

Ohio: Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Oklahoma: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Pennsylvania: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Tennessee: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company. Penalties include imprisonment, fines and denial of coverage.

Virginia: Any person who, with the intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.

Washington: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

Principal Financial Group

Mailing Address:
Des Moines, IA 50392-0002

Principal Life Insurance Company

Authorization for Release of Personal Health and Other Information to Principal Life Insurance Company

I authorize any physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, health care provider, health plan, insurer, and any other entity subject to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) that has provided treatment, service, or coverage to me within the past 10 years to disclose my entire medical record to the Principal Life Insurance Company, its agents, employees, insurance support organizations, reinsurers, and their representatives. This includes information on the diagnosis and treatment of mental illness (excluding psychotherapy notes as defined under HIPAA) and the use of alcohol, drugs, and tobacco.

I understand my personal health information may be used or disclosed as set forth by this authorization. Protected health information includes information created or received by Principal Life. Protected health information also includes but is not limited to: hospital records, treatment records/office notes, alcohol or drug abuse treatment, consultation reports, workers' compensation information, diagnosis, prescriptions, test results, vocational testing/counseling information, benefit information, claims information, demographic information, and claims payment information.

I understand that unless prohibited by state or federal law the protected health information is to be disclosed under this authorization so that Principal Life may administer claims and determine or fulfill responsibility for coverage and provision of benefits and conduct other legally permissible activities that relate to any coverage I have or have applied for with Principal Life.

Also, I authorize any state taxing authority and any employer, former employer, business associate or partners, insurance company or insurance support organization to give any information or record it has about me, my employment, employment history or income to Principal Life.

The following groups of persons employed or working for Principal Life may use my personal health and other information which is described above: employees of the claim or legal departments and any other personnel of Principal Life, and its authorized representatives, and business associates that perform functions or services that pertain to any coverage I have or have applied for with Principal Life. This includes, reinsuring companies, persons or organizations performing business, legal or medical services related to the policy or claim, employer or former employer as needed to perform fiduciary responsibility under any benefit plan and, when required by law, to any other public or private entity or person.

I understand any information disclosed under this authorization may no longer be covered by the privacy provisions of HIPAA and may be subject to redisclosure. This authorization shall remain in force for 24 months following the date of my signature below, and a copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization at any time. The request for revocation must be in writing and sent to: Disability Claims, Life and Health Segment, Principal Life Insurance Company, Des Moines, IA 50392. I understand that a revocation is not effective if Principal Life has relied on the protected health information disclosed to it or has a legal right to contest a claim under an insurance policy or to contest the policy itself.

I understand that if I refuse to sign this authorization to release my complete medical record, Principal Life may not be able to process my application for life or disability coverage, or if coverage has been issued, may not be able to make any such benefit payments. Upon your request, a copy of this completed authorization will be provided to you. Any alteration of this form will not be accepted.

Claimant's signature: _____ **Date:** _____

Claimant's full name: _____ **Date of birth:** _____

Claimant's address: _____

Telephone Number: _____ **Can confidential messages be left at this number?** ☐ **yes** ☐ **no**

Incident number: _____

If you are the representative of the member or the member's dependent (including a member acting as a representative on a dependent's behalf) describe the scope of your authority to act on the member's or dependent's behalf. Please include the proper documentation that attests to your ability to sign.

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