Principal Financial Group

Mailing Address:
711 High Street
Des Moines, IA 50392-0410

Principal Life Insurance Company

Disability Claim Notice

Instructions For Filing A Claim

Please indicate the type of policy and the policy(ies) or account number(s) of your coverage:

- ☐ Individual Disability Income (including Overhead Expense or Buy Out) Policy(ies)
- ☐ Individual Catastrophic Disability Benefit Rider
- ☐ Individual Life – Waiver of Premium Policy(ies)
- ☐ Group Disability – Short Term, Long Term or Group Life Waiver of Premium

Policy/Account Numbers:

_____ _____ _____ _____

_____ _____ _____ _____

- It is important that you read and fully complete all questions on this form. We are unable to begin the evaluation of your claim without this information. An incomplete form may result in a delay in the evaluation of your claim.
- Please complete the top portion of the Health Insurance Portability and Accountability Act Authorization, then read, sign and date. This authorization is in compliance with the Health Insurance Portability and Accountability Act. The authorization will allow us to obtain medical and other information that may be required to make a claim determination.
- Please read, sign and date the Fraud Statement and Insured's Statement on page 4 of this form.

If you have any questions or need assistance, please contact us:

For **INDIVIDUAL DISABILITY** – Phone: (800) 422-3788
Fax: (866) 317-4526
Email: IndividualDisabilityClaims@exchange.principal.com

For **INDIVIDUAL LIFE WAIVER OF PREMIUM** – Phone: (800) 331-2213
Fax: (866) 894-2096

For **GROUP DISABILITY OR GROUP LIFE WAIVER OF PREMIUM** – Phone: (800) 245-1522
Fax: (800) 255-6609

INSURED'S NAME	DATE OF BIRTH	SOCIAL SECURITY NUMBER

RESIDENTIAL ADDRESS

MAILING ADDRESS, IF DIFFERENT	EMAIL ADDRESS

HOME PHONE NUMBER	WORK PHONE NUMBER	CELL PHONE

CLAIM INFORMATION (please indicate all that are applicable)
(NOTE: Must show applicable disability dates, if no dates the form will be returned to be completed.)

☐ Total Disability – Date you completely stopped working	_____	Date Returned to Work	
☐ Partial Disability – Date you began working part time	_____	☐ Full Time	_____
☐ Catastrophic Disability – Date began	_____	☐ Part Time	_____
☐ Capital Sum Benefit – Date began	_____	☐ Plan to Return	_____

Date your Injury occurred or Sickness began _____. Please provide details of accident or nature of sickness

Please provide information on all employers and occupations you were working in before your disability began.

What was your occupation(s) at the time disability began?
If there is a written job description for your occupation, **please attach a copy**
Employer's or Company's Name:
Address:
Name of Supervisor: Phone No.
Do you have an ownership interest in the business? ☐ NO ☐ YES Percent of ownership? %
If yes, type of business entity: ☐ Sole Proprietor ☐ S-Corporation ☐ C-Corporation ☐ Limited Liability (LLC)
What was your monthly earned income (**after** business expenses) just prior to your disability? $
Is any portion of the policy premium paid by your employer? ☐ NO ☐YES If yes %
If yes, what percentage of the premium does your employer include in your income: %

List all important duties of your occupation and the number of hours spent per week at each duty for the period immediately preceding the date of disability.

DUTIES	**NO. OF HOURS SPENT/WEEK**
Total number of hours you normally worked at your occupation.	

List the number of hours spent each day in your occupation performing the following activities.

Sitting	hrs/day	Walking	hrs/day	Standing	hrs/day
Traveling	hrs/day	What is the average distance traveled during a day?			
Lifting	hrs/day	Average weight lifted	lbs.	Maximum weight lifted	lbs.

Describe which duties and activities you are unable to perform as a result of your disability and why.

If partially disabled, how many hours per day are you currently working? _____ and what duties and activities are you performing? _____

What Other Disability, Overhead Expense or BuyOut policies do you have? ☐ **None**

NAME OF COMPANY:
POLICY NO: Type of coverage: ☐ Disability ☐ Overhead Expense ☐ Buy Out
CONTACT PERSON: PHONE NO:
NAME OF COMPANY:
POLICY NO: Type of coverage: ☐ Disability ☐ Overhead Expense ☐ Buy Out
CONTACT PERSON: PHONE NO:
NAME OF COMPANY:
POLICY NO: Type of coverage: ☐ Disability ☐ Overhead Expense ☐ Buy Out
CONTACT PERSON: PHONE NO:

Worker's Compensation

Have you or will you be filing a Worker's Compensation Claim?	☐ NO	☐ YES, if yes provide the following:
NAME OF WORKER'S COMPENSATION COMPANY:		
WC CLAIM NO:	ARE BENEFITS BEING PAID? ☐ YES ☐ NO	
CONTACT PERSON:	PHONE NO:	

SOCIAL SECURITY BENEFIT INFORMATION

Have you applied for: ☐ Social Security Disability Benefits or ☐ Social Security Retirement Benefits	
If yes, date applied:	
Indicate if you are receiving	☐ Social Security Primary Disability Benefits
	☐ Social Security Family Benefits
	☐ Social Security Retirement Benefits
What is the effective date of your approval?	
Please attach a copy of your determination letter from Social Security.	

If your disability was the result of an auto accident or covered by liability coverage, please provide the following:

NAME OF YOUR AUTO INSURANCE CARRIER:	
POLICY NO:	
CONTACT PERSON:	PHONE NO:

NAME OF OTHER PARTY'S AUTO INSURANCE OR LIABILITY CARRIER:	
POLICY NO:	
CONTACT PERSON:	PHONE NO:

Please provide all the health care providers and hospitals who have treated you for this disability (if necessary attach a separate piece of paper).

NAME:	
ADDRESS:	CITY/STATE/ZIP:
PHONE NO:	FAX NO:
REASON:	DATE (S):
NAME:	
ADDRESS:	CITY/STATE/ZIP:
PHONE NO:	FAX NO:
REASON:	DATE (S):
NAME:	
ADDRESS:	CITY/STATE/ZIP:
PHONE NO:	FAX NO:
REASON:	DATE (S):
NAME:	
ADDRESS:	CITY/STATE/ZIP:
PHONE NO:	FAX NO:
REASON:	DATE (S):
NAME:	
ADDRESS:	CITY/STATE/ZIP:
PHONE NO:	FAX NO:
REASON:	DATE (S):

Please provide the names of any health care providers and hospitals you were treated at in the past 5 years

NAME:	
ADDRESS:	CITY/STATE/ZIP:
PHONE NO:	FAX NO:
REASON:	DATE (S):
NAME:	
ADDRESS:	CITY/STATE/ZIP:
PHONE NO:	FAX NO:
REASON:	DATE (S):
NAME:	
ADDRESS:	CITY/STATE/ZIP:
PHONE NO:	FAX NO:
REASON:	DATE (S):
NAME:	
ADDRESS:	CITY/STATE/ZIP:
PHONE NO:	FAX NO:
REASON:	DATE (S):

ALL OTHER STATES

Fraud Statement: Any person who knowingly and with intent to defraud any insurance company or other person, submits a statement of claim or any application form containing any material false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act which is a crime. Such actions may be considered felonies and subject to criminal and civil penalties, including imprisonment and fines. See pages 5 and 6 for your specific state language.

Signature

Date MM/DD/YYYY

Continue to Authorization

Fraud Statements

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.
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.
DC Residents **Washington**	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 subject.
Florida	Any person who knowingly and with intent to injure, defraud, or deceive any insurance company files a statement of claim containing any false or misleading information is guilty of a felony of the third degree.
Indiana	Any person who knowingly and with intent to injure, defraud, or deceive any insurance company files a statement of claim containing any false or misleading information is guilty of a felony of the third degree.
Kentucky	Any person who knowingly and with intent to defraud any insurance company or files a statement of claim containing any materially false or 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 and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Minnesota	A person who files a claim with intent to defraud or helps commit fraud against an insurer is guilty of a crime.
New Jersey	Any person who knowingly files a statement of a 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.
New York	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 shall also be subject to a civil penalty not to exceed five thousand dollars and stated value of the claim for each such violation.
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 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.
Oregon	Any person who, with intent to defraud or knowing that he/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.
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 purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.
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.

Intentionally Left Blank

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/or 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 medical information concerning the diagnosis or treatment of: Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases AND mental illness (including 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.

By my signature, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct any physician, health care professional, hospital, clinic, medical facility, other health care provider or health plan, insurer, or other entity subject to HIPAA to release and disclose my medical record without restriction.

I understand that unless prohibited by state and/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, coordinate the provision of benefits under my medical and disability coverages, and conduct other legally permissible activities that relate to any coverage I have or have applied for with Principal Life.

Also, I authorize the Internal Revenue Service, Social Security Administration, any state taxing authority, current or former employer(s), business associates or partners, insurance company, insurance support organization, Worker's Compensation or Vocational or Rehabilitation Counselor or provider to give any information or record it has about me, including, but not limited to employment, employment history or income to Principal Life Insurance Company.

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 underwriting, administration, 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, have applied for, or may in the future apply 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: Individual Disability Claims, Life and Health Segment, Principal Life Insurance Company, Des Moines, IA 50392-0410. 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 or other information, Principal Life may not be able to process my application for life and/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.

OPTIONAL: I give you permission to speak to _____ (full name) ☐ my spouse, ☐ domestic partner, or ☐ _____, concerning my claim during my disability.

INSURED'S PRINTED NAME _____ POLICY NO: _____

INSURED'S SIGNATURE _____ DATE: _____

INSURED'S DATE OF BIRTH: _____

If you are the representative of the Insured signing on their behalf, please include the proper documentation that attests to your ability to sign (i.e. court-stamped Letters of Appointment of the Executor of Estate, proof of custody, power of attorney, etc.).