

## Disability Claim Notice

711 High Street, Des Moines, IA 50392

Call: 800-422-3788

Fax: 866-317-4526

Email: [IndividualDisabilityClaims@exchange.principal.com](mailto:IndividualDisabilityClaims@exchange.principal.com)



**The following information is needed to apply for Individual Disability benefits.  
Incomplete forms may result in a delay in the evaluation of the claim.**

- Disability Claim Notice and HIPAA Authorization.
- Attending Physician's Statement and/or Psychiatric Questionnaire. This form needs to be completed by the treating physician.
- Complete copies of personal and business (if applicable) tax returns for the 2 years prior to the date of disability. Please include all schedules, attachments, and W-2's.
- Year-to-date profit and loss statements and/or paystub prior to disability and monthly ongoing profit and loss statements and/or paystubs after disability.
- Job Description, if available.

Once ready, please submit your paperwork to Principal by mail, fax or email.

**INDIVIDUAL DISABILITY** 711 High Street  
Des Moines, IA 50392  
Call: (800) 422-3788  
Fax: (866) 317-4526  
Email: [IndividualDisabilityClaims@exchange.principal.com](mailto:IndividualDisabilityClaims@exchange.principal.com)

Please keep this page for your records.

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**If necessary, attach extra sheets to explain any responses.**

Name: \_\_\_\_\_ Policy #(s): \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Address: \_\_\_\_\_

Phone #(s): \_\_\_\_\_  Cell  Home  Work \_\_\_\_\_  Cell  Home  Work

Email Address: \_\_\_\_\_

May we contact you by email?  No  Yes

Date you are claiming disability: \_\_\_\_\_

Date last worked: \_\_\_\_\_

If the date last worked is different than the date of disability, please explain: \_\_\_\_\_

\_\_\_\_\_

Date(s) worked part-time due to disability: \_\_\_\_\_

\_\_\_\_\_

Return to full-time work date: \_\_\_\_\_

Please explain your disability: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**OCCUPATIONAL INFORMATION**

What was your occupation(s) at the time your disability began? \_\_\_\_\_

\_\_\_\_\_

Employer or company name: \_\_\_\_\_

Address: \_\_\_\_\_

Employer/HR contact person: \_\_\_\_\_ Phone number: \_\_\_\_\_

Do you have any ownership interest in the business?  No  Yes If yes, \_\_\_\_\_%

If yes, type of business entity:

Sole Proprietor  S-Corporation  C-Corporation  Limited Liability (LLC)

Is any portion of the policy premium paid by your employer?  No  Yes If yes, \_\_\_\_\_%

If yes, are premiums included as income?  No  Yes

Name: \_\_\_\_\_

Policy #(s): \_\_\_\_\_

Job Duties	Number 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:

Sitting \_\_\_\_\_ hrs./day

Walking \_\_\_\_\_ hrs./day

Standing \_\_\_\_\_ hrs./day

Lifting \_\_\_\_\_ hrs./day      Average weight \_\_\_\_\_ lbs.

Traveling \_\_\_\_\_ hrs./day      Average distance traveled during a day? \_\_\_\_\_ Miles

Describe which duties you are unable to perform because of your disability, and why:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Describe how your inability to perform these duties impacts your earnings:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

If working, how many hours per day are you currently \_\_\_\_\_

Please describe which duties are you performing? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Name: \_\_\_\_\_

Policy #(s): \_\_\_\_\_

**OTHER DISABILITY INSURANCE POLICY(IES) IN FORCE**

No Other coverages

Insurance company: \_\_\_\_\_ Policy #(s): \_\_\_\_\_

Claims contact person: \_\_\_\_\_ Phone number: \_\_\_\_\_

Type of coverage:

Individual    Short-term disability    Long-term disability    Overhead Expense    Buy Out

Insurance company: \_\_\_\_\_ Policy #(s): \_\_\_\_\_

Claims contact person: \_\_\_\_\_ Phone number: \_\_\_\_\_

Type of coverage:

Individual    Short-term disability    Long-term disability    Overhead Expense    Buy Out

**WORKERS 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: \_\_\_\_\_

Claim#: \_\_\_\_\_ Are benefits being paid?    No    Yes

Claims contact person: \_\_\_\_\_ Phone number: \_\_\_\_\_

**SOCIAL SECURITY BENEFIT INFORMATION**

Have you applied for:    Social Security Disability Benefits    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

**Please attach a copy of your determination letter from Social Security.**

Name: \_\_\_\_\_

Policy #(s): \_\_\_\_\_

**DOCTOR/FACILITY INFORMATION**

Please provide the following information for all doctors that have treated you for your disability.

Name of Provider and/or Facility: \_\_\_\_\_

Specialty: \_\_\_\_\_

Address: \_\_\_\_\_

Phone#: \_\_\_\_\_ Fax#: \_\_\_\_\_

Reason: \_\_\_\_\_ Date(s): \_\_\_\_\_

Name of Provider and/or Facility: \_\_\_\_\_

Specialty: \_\_\_\_\_

Address: \_\_\_\_\_

Phone#: \_\_\_\_\_ Fax#: \_\_\_\_\_

Reason: \_\_\_\_\_ Date(s): \_\_\_\_\_

Name of Provider and/or Facility: \_\_\_\_\_

Specialty: \_\_\_\_\_

Address: \_\_\_\_\_

Phone#: \_\_\_\_\_ Fax#: \_\_\_\_\_

Reason: \_\_\_\_\_ Date(s): \_\_\_\_\_

Name of Provider and/or Facility: \_\_\_\_\_

Specialty: \_\_\_\_\_

Address: \_\_\_\_\_

Phone#: \_\_\_\_\_ Fax#: \_\_\_\_\_

Reason: \_\_\_\_\_ Date(s): \_\_\_\_\_

Name of Provider and/or Facility: \_\_\_\_\_

Specialty: \_\_\_\_\_

Address: \_\_\_\_\_

Phone#: \_\_\_\_\_ Fax#: \_\_\_\_\_

Reason: \_\_\_\_\_ Date(s): \_\_\_\_\_

Name: \_\_\_\_\_

Policy #(s): \_\_\_\_\_

Name of Provider and/or Facility: \_\_\_\_\_

Specialty: \_\_\_\_\_

Address: \_\_\_\_\_

Phone#: \_\_\_\_\_

Fax#: \_\_\_\_\_

Reason: \_\_\_\_\_

Date(s): \_\_\_\_\_

**Whether you are a New York resident or not, please sign and date below. If you are a resident of another state please see the attached list of state specific fraud statements.**

**New York Fraud Statement:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim contacting any materially false 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.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**Continue to HIPAA Authorization**

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

Principal Life Insurance Company  
Attn: DI Claims Department  
Des Moines, Iowa 50392-0002  
Call: 800-422-3788 Fax: 866-317-4526  
Email: [IndividualDisabilityClaims@exchange.principal.com](mailto:IndividualDisabilityClaims@exchange.principal.com)



I authorize any physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, health care provider, health plan and its administrator, disability plan and its administrator, insurer, 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 to disclose my entire medical record to the Principal Life Insurance Company (Principal Life), 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, 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 and any employer, former employer, business associate 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, 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: Individual 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:** \_\_\_\_\_ **Policy #** \_\_\_\_\_

**Claimant's full name:** \_\_\_\_\_ **Date of birth:** \_\_\_\_\_

**Claimant's address:** \_\_\_\_\_

**Telephone number:** (\_\_\_\_\_) \_\_\_\_\_ **Can confidential messages be left at this number?**      **yes**      **no**

OPTIONAL: I give you permission to speak with \_\_\_\_\_ (full name)      My spouse,

Domestic Partner, or \_\_\_\_\_, concerning my claim during my disability.

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.

I certify that I am a citizen of the following country:

\_\_\_\_\_ (Country)      \_\_\_\_\_ (Signature)      \_\_\_\_\_ (Date)

## FRAUD STATEMENTS

### Non- State Specific Fraud Statement

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

### 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."

### Alaska

A person who knowingly and with intent to injure, defraud, or deceive an insurance company, files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

### 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.

### 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 policy holder or claimant for the purpose of defrauding or attempting to defraud the policy holder 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.

### Delaware

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

### 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.

### 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.



<b>Indiana</b>
A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.
<b>Kentucky</b>
Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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.
<b>Louisiana</b>
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.
<b>Maine</b>
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.
<b>Minnesota</b>
A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.
<b>New Hampshire</b>
Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in New Hampshire law.
<b>New Jersey</b>
Policy application Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.
<b>New Mexico</b>
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.
<b>North Carolina</b>
Any person who, with the intent to injure, defraud, or deceive an insurer or insurance claimant: <ol style="list-style-type: none"> <li>1. Presents or causes to be presented a written or oral statement, including computer-generated documents as part of, in support of, or in opposition to, a claim for payment or other benefit pursuant to an insurance policy, knowing that the statement contains false or misleading information concerning any fact or matter material to the claim, or</li> <li>2. Assists, abets, solicits, or conspires with another person to prepare or make any written or oral statement that is intended to be presented to an insurer or insurance claimant in connection with, in support of, or in opposition to, a claim for payment or other benefit pursuant to an insurance policy, knowing that the statement contains false or misleading information concerning a fact or matter material to the claim is guilty of a Class H felony.</li> </ol>
<b>Ohio</b>
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 <b>is</b> 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 and 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.

**Rhode Island**

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.

**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.

**Texas**

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.

**Virginia**

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.

**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.