Disability Claim Notice

Principal Life Insurance Company
711 High Street, Des Moines, IA 50392
Call: 800-422-3788
Fax: 866-317-4526
Email: 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 Life Insurance Company 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

Please keep this page for your records.

Principal Life Insurance Company
711 High Street, Des Moines, IA 50392
Call: 800-422-3788
Fax: 866-317-4526
Email: IndividualDisabilityClaims@exchange.principal.com

Claim Handling and Timing Expectations for Insureds and Representatives

- You will need to provide:
  - **Disability Claim Notice**
  - **Valid HIPAA Authorization**
  - **Attending Physician Statement** and/or **Psychiatric Questionnaire** completed by your restricting physician(s) in order for us to start our review of your claim.
- It is our goal within 10 business days from when claim forms are received, to:
  - send you an **Initial Status Letter** notifying you of any additional information that is needed.
  - call you to conduct a **phone interview** to gather more details surrounding your claim. (This is part of our standard procedure and cannot be waived.)
- We may also request an **in-person home visit** be completed by our field representative to get to know you better and obtain more information surrounding your claim. The field representative will contact you directly to schedule this meeting.
- We will request the necessary **medical documentation** from your treating providers to validate your claim. This process is completed by a 3rd party vendor. Requests are sent directly to your provider(s) office and are continuously followed-up on until information is received. We will notify you if a special authorization is required. If you would like to help expedite requests, please notify your physician that records are being requested.
- In order to help us better understand your medical condition and your restrictions and limitations as set forth by your treating physician(s), we will have a **Medical Review** completed. These reviews can take 2 weeks once all pertinent medical documentation is received. An Independent Medical Exam (IME) or Functional Capacity Evaluation (FCE) may also be needed to further validate your claim. If we have an IME or FCE scheduled it is important for you to attend the scheduled appointment. These exams will be scheduled at no cost to you.
- We may request **financial documentation**, including complete copies of your Tax Returns, W2s, wage statements, production reports, or any other financial information deemed necessary to determine your prior earnings. If you are working part time similar information may be requested to determine your current earnings.
- A **Status Letter** is sent every 30 days notifying you of outstanding proof of loss needed to process your claim.
- Once all proof of loss is received and reviewed, we will **make a determination** within 10 business days. Once a claim decision has been made, you will be notified in writing and issued any benefits due on the claim. If ongoing payments are due, you will have the option of having future benefits deposited via direct deposit.
- Benefits are not payable during your Elimination Period (EP). If benefits have not accrued by the time a decision is rendered, a benefit will be issued 30 days after your EP has been met. If our claim review is completed after the EP has been met, we will issue past due benefits retroactively to the accrual date.
- You will need to continue to **pay premiums** while your claim is being processed. If your claim is approved, we will also **refund all premiums** paid since your disability began and will waive premiums as long as you continue to be disabled and meet all policy requirements.

If you are unable to speak over the phone due to your medical condition, we will speak to an authorized representative listed on the HIPAA Authorization.

Disability Claim Notice

Principal Life Insurance Company
711 High Street, Des Moines, IA 50392
Call: 800-422-3788
Fax: 866-317-4526
Email: IndividualDisabilityClaims@exchange.principal.com

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 ☐ Partnership

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 lifted? _____ 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:

Are you currently working? ☐ No ☐ Yes If Yes, how many hours per day are you working? _____

Please describe which duties you are 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 the 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
711 High Street, Des Moines, IA 50392
Call: 800-422-3788
Fax: 866-317-4526
Email: 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, 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:** _____ **Incident #** _____

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.

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.

Indiana
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.

Kentucky
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.

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.

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.

Minnesota
A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

New Hampshire
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.

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.

North Carolina
Any person who, with the intent to injure, defraud, or deceive an insurer or insurance claimant: 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 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.

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.

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.