Instructions for Applying for Disability Benefits Payments

Administered by
Principal Life Insurance Company
Attn: Group Life and Disability Claims Department
Des Moines, Iowa 50392-0002
Toll free Nationwide 800-245-1522
Toll free fax 800-255-6609
Email: SBDClaims@principal.com

Applying for Disability Benefits Payments

The attached forms are required to be completed to apply for your disability benefits through our claims process. These forms must be completed in their entirety by your employer, you and your attending physician. If you have additional information you feel would be pertinent to review for this claim please attach to this form.

1. ☐ Read the Notice Requirements on Page 1 and 2.
2. ☐ Your employer needs to complete the Employer Statement on page 3
3. ☐ You need to complete and sign the Employee Statement, located on page 4.
   - **If your disability benefit is taxable, voluntary withholding for State and/or Federal income tax is available at your request.**
4. ☐ Have your treating physician complete and sign the Attending Physician Statement, also located on page 4 and continues to page 5. If more than one physician is treating you for your disabling condition, each should complete a form. Additional forms are available from your employer's benefit administrator. Your physician may return the completed form to you or send directly to us with the other completed forms listed above. Your physician may mail, fax or email the completed form using the contact information listed below.
5. ☐ Sign and date page 6, the Authorization of Release of Personal Health Information. This authorization allows us to request further information about your claim if necessary.
6. ☐ **Once all sections of this form are completed,** please submit to Principal by mail, fax or email.

   Group Life and Disability Claims Department
   Des Moines, Iowa 50392-0002
   Call: 800-245-1522 **Fax:** 800-255-6609
   Email: SBDClaims@principal.com

To avoid unnecessary delays, be sure all parts of these Claim Forms are completed according to the instructions listed above. Once forms are received, we will be able to begin our evaluations.

If you have any questions about your claim form, please call 800-245-1522 between the hours of 7:30 am and 5:00 pm CST

What to Expect Once You Submit Your Claim Request for Disability Payments

After your claim is submitted, a claims specialist may need to gather any additional information from you, your employer, and/or your health care provider(s). If your request for benefit payment is approved, you will receive your Short Term Disability payments weekly. You can expect a call from your Principal claim specialist to discuss the following in greater detail.

- Return-to-work possibilities
- Proposed treatment plan
- Daily activities
- Social Security disability status

The focus for any claim request is to look at return–to–work opportunities in your regular job using:

- Job Modification or restructuring
- On-the-job therapy to assist with work related duties
- Possible temporary placement to another job until you can return to normal duties.

When you Return to Work

You need to notify Principal when you plan to return to work, either part-time or full-time, or have returned to work already to avoid any overpayments.

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.

Disability Claim Form
Employer Statement

Administered by
Principal Life Insurance Company
Attn: Group Life and Disability Claims Department
Des Moines, Iowa 50392-0002
Toll free Nationwide 800-245-1522
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Email: SBDClaims@principal.com

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To be completed and signed by the employer

Employee's name:	Phone Number:		DOB:
Employee's address:	City:	State:	Zip Code:
Social Security Number:	Employee's job title:		I.D. number:

Products filing for with Principal: Long Term Disability: ☐ Short Term Disability: ☐ Life Waiver: ☐

Is the employee an owner/partner in the company? Yes: ☐ No: ☐ **If yes**, designated owner percentage %

Employment Status

Date of Employment: _____ Date employee last worked: _____ # of hrs worked on last day: _____

Actual hours employee worked per week: _____ **Hourly employees**: Excess of 40 hours per week considered overtime? Yes ☐ No ☐

Return to work? Yes ☐ No ☐ **If yes,** Part time ☐ or Full time ☐ Date returned:

Financial Information

Employee base salary: $ _____ Hourly ☐ Weekly ☐ Monthly ☐ Annually ☐ Date of last pay increase: _____

Salary prior to increase $ _____ Does the employee earn any commissions or bonuses? Yes ☐ No ☐

Percentage of premium paid by employer: _____ % **If less than 100%,** were premiums paid with employee's **pre-tax$** ☐ **post tax$** ☐

Do you bonus/gross up employees' salary to cover premiums? Yes ☐ No ☐

Is disability due to employment? Yes ☐ No ☐ **If yes**, Filed for workers comp? Yes ☐ No ☐ Filed for state disability? Yes ☐ No ☐

Was salary continued after last day worked? Yes ☐ No ☐ **If yes, how?** Salary continuance ☐ Date paid through: _____

Vacation ☐ Paid through: _____ Sick pay ☐ Paid through: _____ PTO ☐ Paid through: _____

If Worker's Compensation is approved or denied, please attach a copy of the award/denial letter with this claim.

Job Description Questionnaire (JDQ)

If you have already submitted a job description with physical requirements, you do not need to complete the section below with physical requirements.

In a typical work day, the employee's job involves:

Sitting _____ Hours at one time. _____ Total hours during a regular work day.

Standing _____ Hours at one time. _____ Total hours during a regular work day.

Walking _____ Hours at one time. _____ Total hours during a regular work day.

Definitions:

Continuously **(C)** – 6-8 hours in an 8-hour day or 60 times per hour: Frequently **(F)** – 3-6 hours in an 8-hour day or up to 12-60 times per hour:
Occasionally **(O)** – up to 3 hours in an 8-hour day or 1-12 times per hour: Never **(N)**

	Continuously	Frequently	Occasionally	Never
Lifting	**lbs.**	**lbs.**	**lbs.**	☐
Carrying	**lbs.**	**lbs.**	**lbs.**	☐

Hand Use	C	F	O	N	**Reaching**	C	F	O	N
Simple grasping	☐	☐	☐	☐	Reach above shoulder level	☐	☐	☐	☐
Power grasping	☐	☐	☐	☐	Reach at waist level	☐	☐	☐	☐
Pushing & pulling	☐	☐	☐	☐	Reach below waist level	☐	☐	☐	☐
Fine manipulation	☐	☐	☐	☐	Keyboarding	☐	☐	☐	☐

Positioning	C	F	O	N		C	F	O	N
Bends (waist level)	☐	☐	☐	☐	Twists (waist level)	☐	☐	☐	☐
Squats	☐	☐	☐	☐	Crawls	☐	☐	☐	☐
Kneels	☐	☐	☐	☐	Balancing	☐	☐	☐	☐
Climbs (ladders)	☐	☐	☐	☐	Climbs (stairs)	☐	☐	☐	☐

Travels for work? Yes ☐ No ☐ If Yes, How often?

Can you accommodate part time work? Yes ☐ No ☐ Possibly ☐ Light duty work? Yes ☐ No ☐ Possibly ☐

Employer Name: _____ **Plan Number:** _____ **Unit Number:** _____

Date: _____ **Signature:** X _____ **Title:** _____

Telephone Number: **FAX Number:** **Email Address:**

Employee Statement

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Email: SBDClaims@principal.com

Please complete the following information along with the Authorization for Release of Personal Health and other Information found on page 7.

I declare that all the below statements on this form are true and completed to the best of my knowledge. I acknowledge I have read the Notice Requirements on page 1 and 2 of this form.

Name: _____ Date of Birth: _____ Gender: Male ☐ Female ☐

Social Security #: _____ Street Address: _____

City: _____ State: _____ Zip Code: _____ Email Address: _____

Phone Number: Home: ☐ Cell: ☐ Work: ☐ What's your Preferred Language?

The date your medical leave began: _____ Cause of leave: Injury ☐ Illness ☐ Pregnancy ☐ Please describe the cause of leave in detail. Depending on situation include date, time, place of occurrence, and include a copy of the accident report. If illness, nature of illness and date

Was a Motor Vehicle Accident involved? Yes ☐ No ☐ **If yes**, Auto Insurance carrier name: _____

Insurance phone number: _____ Policy number: _____ **Please include copy of the police report**

Is Injury/illness due to employment? Yes ☐ No ☐ Filed for Workers Compensation? Yes ☐ No ☐ **If yes,** date filed: _____

If approved, amount received $ _____ Frequency of payments Weekly ☐ Bi-Weekly ☐ Monthly ☐ Other ☐ Specify: _____

(If Worker's Compensation is approved or denied, please attach a copy of the award or denial letter with this claim.)

Do you have a personally owned individual disability policy with Principal? Yes ☐ No ☐ **If yes**, please list policy numbers: _____

Is any portion of the individual disability policy premium paid by your employer? Yes ☐ No ☐ **If yes**, _____ %

If Yes, what percentage of the premiums does your employer include in your income? _____ %

Do you have other disability insurance with other companies? Yes ☐ No ☐ **If yes**, please list policy numbers: _____

Other benefits you have applied for or are receiving: State Disability ☐ Pension ☐ Social Security (Early Retirement) ☐ Social Security (Disability) ☐

Social Security (Widows) ☐ Social Security (Retirement) ☐ Date income began: Amount: $

Names of doctors, practitioners and hospitals	Telephone Number	Date confined/consulted	Reason for confinement/consultation

I give permission to accept text messages about my claim: ☐ Yes ☐ No **If Yes**, phone number: _____

Name of your cell phone provider: _____ **Standard text-message and data rates may apply.**

Notice requirements:

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.

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 the stated value of the claim for each such violation.

Signature: X **Date:**

Attending Physician Statement - To be completed by your Physician – Include office notes and test results from date of disability to present

The following information is needed to document the patient's inability to work. The patient is responsible for obtaining a complete form without expense to Principal. Please complete this form and mail or fax it to Principal using the contact information listed above.

1 Patients Name: | Date of Birth:

2 Social Security #: | Height: | Weight:

3 Patient is/was unable to work due to : Injury ☐ Illness ☐ Pregnancy ☐ | **If pregnancy,** Skip to question 19

4 List all ICD-10 Diagnosis Code(s):

5 List any complications your patient is experiencing:

6 Objective Findings **(X-rays, EKG's, MRI results, lab data and clinical findings)**

7 Subjective Symptoms

8 Please provide date symptoms first appeared or accident happened?

9 Is the condition due to injury or illness arising from of your patient's employment? Yes ☐ No ☐

10 Did this condition already exist and become exacerbated by employment? Yes ☐ No ☐

If yes, please explain:

11 **Is patient competent to endorse checks and direct the use of those proceeds?** Yes ☐ No ☐

12 Date of first visit	**13** Date of last visit	**14** Date of next visit	**15** Frequency of visits

16 Has your patient been hospitalized? Yes ☐ No ☐ If Yes, From date: To date:

Hospital Name: Phone Number:

17 Has your patient ever had the same or similar condition? Yes ☐ No ☐ **If yes**, when

18 **NATURE OF TREATMENT – Please specify all surgeries, medications AND dosage, therapy, and/or referrals.**

Date of Surgery Type of surgery CPT-4 Codes

If the patient was referred to you or by you to another physician list the Physician's name, address and phone number of the Physician:

19 **PREGNANCY SUBMISSIONS ONLY**

What is the expected date of delivery?	Date first treated	Date last treated	Date of delivery

Bed confined? Yes ☐ No ☐ **If yes**, Date From: To: Type of delivery: Vaginal ☐ C-Section ☐

If complications are present prior to delivery, what complications is your patient experiencing?

20 **PHYSICAL IMPAIRMENT**

After discussing job duties with your patient, please provide the specific restrictions and limitations you have placed on your patient in the space provided below:

	CONTINUOUSLY (2/3 + of time)	**FREQUENTLY (1/3 – 2/3 of time**	**OCCASIONALLY (Up to 1/3 of time)**	**NEVER**
Sit	☐	☐	☐	☐
Stand	☐	☐	☐	☐
Walk	☐	☐	☐	☐
Lift/Carry	lbs.	lbs.	lbs.	lbs.
Power Grasp	☐	☐	☐	☐
Fine Manipulation	☐	☐	☐	☐
Push/Pull	☐	☐	☐	☐
Keyboarding	☐	☐	☐	☐
Reach above shoulder level	☐	☐	☐	☐
Reach at waist level/below waist	☐	☐	☐	☐
Bend/Twist/Squat	☐	☐	☐	☐
Climb/Balance	☐	☐	☐	☐

Continued from page 5

21 **PROGNOSIS:**

Date you recommended your patient to stop working? _____

How long do you expect these limitations and restrictions to impair your patient? ☐ Date: _____ ☐ Permanently

☐ Unable to determine, follow-up in _____ weeks Do you support return to work with the limitations listed above at this time? Yes ☐ No ☐

Do you support return to work on a part time basis? Yes ☐ No ☐ **If yes**, how many hours per day? _____

22

Physician Name (Please Print) _____ **Degree** _____

Specialty _____ **Phone Number** _____ **FAX Number** _____

Address _____ **City** _____ **State** _____ **Zip Code** _____

Tax ID Number: **NPI Number:**

I certify the answers I have made to the above questions are complete and true to the best of my knowledge and belief.

Signature (No Stamp) **X** **Date**:

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

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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 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: 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.

Employee Signature: _____ **Date:** _____

Employee Full Name: _____ **Date of Birth:** _____

Employee Address: _____

Main Contact/Personal Email address: _____

Telephone Number: _____ **Can Confidential messages be left at this number?** Yes ☐ No ☐

OPTIONAL: I give you permission to speak with (Full Name): _____

Spouse ☐ Domestic Partner ☐ Other ☐ (Relationship) _____ ,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)**

Print

