Disability and Life Waiver Benefits Claim Instructions

Administered by
Principal Life Insurance Company
Attn: Group Life and Disability Claims
PO BOX 14472
Des Moines, Iowa 50306-3472
Ph 800-245-1522 Fax 800-255-6609
Email: SBDClaims@principal.com

Don't Forget! You can submit claims directly on the web at www.principal.com/FileAClaim

If your disability claim includes another coverage (PFML, Critical Illness, Accident, or Hospital Indemnity), a coverage specific Physician Statement is required in addition to the one provided with this form. These are available through your employer's benefit administrator or at www.principal.com. Only select coverages that you're enrolled in and are claiming benefits for this condition. For more benefit details, log into your member profile online at accounts.principal.com.

Application Process

The included forms are required to apply for group disability and/or life waiver benefits. They must be completed in their entirety by you, your employer and any treating provider(s). Below are the steps required to submit your claim within 30 days of your expected date of disability.

Questions? Contact 800-245-1522 from 7:30 am to 5:00 pm CT.

- ☐ Read the Notice Requirements for your state (pages 2, 4)
  Notices are listed both before the Employee Statement and above the signature section.
- ☐ Complete and Sign the Employee Statement (pages 3, 4)
  Include a copy of any additional documentation you'd like to send with your claim.
- ☐ Request Employer Statement (pages 5-7)
  To process your claim, your employer needs to fill out a statement. They can file online at www.principal.com/FileAClaim or you can provide them a copy of the form in this packet.
- ☐ Request Attending Physician Statement (pages 8-10)
  We'll need statements from all providers you're seeing related to this claim. They can file online at www.principal.com/FileAClaim, or a single statement form is included in this packet. Additional copies are available through your employer's benefit administrator.
- ☐ Sign and date the Authorization of Release of Personal Health Information (page 11)
  This is a standard HIPAA release and allows us to request further information related to this claim.
- ☐ OPTIONAL: Sign and date the Consent to do Business Electronically (page 12)
  This form allows us to communicate with you through email which can reduce delays in claim processing. Permission can be revoked at any time.
- ☐ OPTIONAL: Complete, sign and date the Authorization Agreement for Electronic Funds Transfer (page 13)
  This form allows us to deposit any benefits directly into your bank account. Choosing direct deposit can cut down on the amount of time it takes to get your payment if your claim is approved.

Next Steps after Submission

Once we receive your claim request, we start working! You'll shortly receive an acknowledgement letter, either through the mail or digitally, acknowledging that we've received your claim.

A claims specialist will reach out to you to gather more information, clarify any questions about your submission, and go over the expected timeline of your claim. We may also reach out to your employer or provider(s) to gather more information if necessary.

Notice Requirements

General Notice: Any person who, with intent to defraud or knowing that they are facilitating fraud against an insurer, submits an application or files a claim containing a false or deceptive statement, may be guilty of insurance fraud.

OR

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 false or fraudulent information to obtain or amend insurance coverage or to make a 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 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 RSA 638:20.

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 they are 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 they are 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 and Life Waiver Benefits Claim Employee Statement

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Basic Information

***Required Field**

Employee Name*			**Email**		
Social Security #*		**Date of Birth***		**Pref. Language**	
Street Address*	Street				
	City		State	ZIP	
Mailing Address if Different					

☐ By checking this box, I'm noting that I work in the state of _____, a different state than listed above.

Phone Number*		**Mobile Carrier if Cell # Provided**	

☐ By checking this box I give permission for Principal to text me regarding my claim, understanding that standard text message and/or data rates may apply.

Claim Information

Employer Name*		**Group #**	

Reason for Leave (Check one)	☐ Sickness	☐ Pregnancy	☐ Injury	☐ Mental Health
Benefits Claiming and Enrolled in For This Condition* (Check all that apply)	☐ Disability	☐ Life Premium Waiver	☐ Hospital Indemnity	
	☐ Accident	☐ Critical Illness	☐ Paid Family and Medical Leave (PFML)	
PFML with Principal:	☐ Bonding with a Child	☐ Care for family member	☐ Active Duty/Military Events	☐ Personal/Family Violence
Describe reason for leave* Include date and location when applicable				
Date Leave Began* ☐ Leave date is estimated				

Employment Related?*	☐ Yes ☐ No	**Filed for Workers' Compensation?**	☐ Yes ☐ No	**Motor Vehicle Accident?***	☐ Yes ☐ No

Note: If you check yes on either question above, we require you provide a copy of a police report or Workers Compensation filings with your claim

Other benefits you have applied for OR are currently receiving? (Check all that apply)	☐ State Disability	☐ No Fault Auto	☐ Other disability insurance
	☐ PFML	☐ Unemployment	**If yes, please list carrier(s) and policy number(s):**
	☐ Social Security (Retirement)	☐ Severance	
	☐ Social Security (Disability)	☐ Other	
	☐ Social Security (Widows)	Date began:_____	
	☐ Pension	Amount:_____	

Disability and Life Waiver Benefits Claim Employee Statement - continued

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Provider Information

Please list all providers you've received treatment from for this claim's condition. If you need to list more physicians, please attach an additional sheet containing the below information.

Provider/Physician/Hospital Name*	Phone Number*	Date First Seen*

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.

By signing this form, I declare that all the statements listed are true and completed to the best of my knowledge.

Signature*		Date*	

Disability and Life Waiver Benefits Claim Employer Statement

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Company Information

***Required Field**

Group Policyholder Name*					
Legal Company Name	☐ Same as Above	☐ Other:			
Account #*		**Bill Group #***		**Member Class***	

Employee Information

Employee Name*		**Member ID***	
Job Title*		**Phone Number***	
Social Security #*		**Date of Birth***	
Street Address*	Street		
	City	State	ZIP

☐ By checking this box, I'm noting this employee works in the state of _____, a different state than listed above

Claim Information

Reason for Leave (if known)	☐ Sickness	☐ Pregnancy	☐ Injury
Benefits Claiming and Enrolled in For This Condition* (Check all that apply)	☐ Disability	☐ Life Premium Waiver	☐ Paid Family and Medical Leave (PFML)
	☐ Accident	☐ Critical Illness	

Employment Information and Finances

Date of Hire*		**Hours Worked per Week***		hours	**Owner/Partner?**	☐ Yes, _____% ☐ No
Date Last Worked* Anticipated date if in the future		**# of Hours Worked on Last Day:***		hours	**Date Returning to work** Anticipated date if in the future	☐ Full Time ☐ Part Time

Current Base Pay and Frequency of this Pay*	$_____ ☐ Hourly ☐ Weekly ☐ Bi-weekly ☐ Bi-Monthly ☐ Monthly ☐ Yearly		
Current Pay Effective Date*		**Earns Commission/Bonus***	☐ Commission ☐ Bonus ☐ N/A
Worker's Compensation*	☐ Filed, decision pending ☐ Awarded ☐ Denied ☐ N/A		
Note: Please provide a copy of all Worker's Compensation filings, including award/denial letters, with this statement			

Employee Premium Contributions and Deductions* (leave blank if product not being claimed)

Short Term Disability	**% Paid:** ☐ Pre-Tax ☐ Post-Tax	**Long Term Disability**	**% Paid:** ☐ Pre-Tax ☐ Post-Tax
Hospital Indemnity	**% Paid:** ☐ Pre-Tax ☐ Post-Tax	**Critical Illness**	**% Paid:** ☐ Pre-Tax ☐ Post-Tax
Accident	**% Paid:** ☐ Pre-Tax ☐ Post-Tax		

Is salary bonused up/grossed up to cover premiums*	**Short Term Disability** ☐ Yes ☐ No	**Long Term Disability** ☐ Yes ☐ No

Disability and Life Waiver Benefits Claim Employer Statement - continued

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Pay After Last Day Worked* (fill in all that apply)

Did employee receive full pay after last day worked?*	☐ Yes	☐ No, _____%	☐ None		
Salary Continuance	Date Started	Date Ended	**PTO**	Date Started	Date Ended
Sick Pay	Date Started	Date Ended	**Vacation**	Date Started	Date Ended

Job Description and Requirements

If your company job description lists the physical and travel requirements of the position, you can provide a copy of the description in lieu of filling out the information below.

In a typical work day, this employee's job involves*

Sitting	Hours at once	Total hours daily	**Standing**	Hours at once	Total hours daily	**Walking**	Hours at once	Total hours daily

Effort Definitions	**Hand Skills**	**C**	**F**	**O**	**N**	**Lifting**
Continuously (C): 6-8 hours of an 8-hour day OR >60 times per hour	Power Grasp	☐	☐	☐	☐	☐ Continuously _____lbs
Frequently (F): 3-6 hours of an 8-hour day OR 12-60 times per hour	Push/Pull	☐	☐	☐	☐	☐ Frequently _____lbs
Occasionally (O): <3 hours of an 8-hour day OR 1-12 times per hour	Keyboarding	☐	☐	☐	☐	☐ Occasionally _____lbs
Never (N): Does not perform	Fine Manipulation	☐	☐	☐	☐	☐ Never

Travel for Work?	☐ Yes ☐ No	**Frequency:**	☐ Daily	☐ Weekly	☐ Monthly	☐ Quarterly	☐ Less/Never

Paid Family Medical Leave (PFML)

Only fill out the following items if you're submitting a claim that includes PFML benefits with Principal.

Leave for	☐ Employee Recovery	☐ Family Member Care	
Reason	☐ Serious Health Condition ☐ Care for Family Member	☐ Maternity Leave ☐ Active Duty or Military Events	☐ Bonding with a Child ☐ Personal/Family Violence

Regular Schedule (hours/day)	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday

In the preceding 52 weeks this employee has taken leave for…
If necessary, multiple date ranges can be listed separated by a comma.

Disability	**# of Weeks:**		**Exact Dates:**
PFML	**# of Weeks:**		**Exact Dates:**

☐ This employee has NOT taken any disability or PFML in the preceding 52 weeks

Disability and Life Waiver Benefits Claim Employer Statement – continued

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Gross Quarterly Earnings – PFML ONLY

Please provide gross earnings information for the five (5) most recent completed quarters prior to the leave start date, starting with the most recent. (Ex. 1Q/2025)

Quarter:		**Earnings:**	$
Quarter:		**Earnings:**	$
Quarter:		**Earnings:**	$
Quarter:		**Earnings:**	$
Quarter:		**Earnings:**	$

Employer Reimbursement – PFML ONLY

If the employee received full wages following the date last worked, will the employer be requesting reimbursement?			☐ Yes ☐ No		
If yes, Amount paid:	**$**	**Date benefits began:**		**Date benefits end:**	
Please note by providing this information, you are indicating that you are entitled to receive reimbursement. The employee will not be paid by the PFML benefit. Instead, it will be reimbursed to you. To receive benefits directly, please complete the below Employer reimbursement form. *State of Connecticut claims are not eligible for reimbursement.					

Employer Reimbursement Policyholder Responsibilities – PFML ONLY

Policyholder as an agent of Principal® understands and acknowledges that it is the responsibility of Policyholder to withhold and remit accurate taxes from compensation paid to the employee representing the PFML benefit.

Policyholder as an agent of Principal understands and acknowledges that it is the responsibility of Policyholder to report compensation representing PFML benefits on Form W-2 and/or Form 1099-MISC.

Policyholder agrees to indemnify, hold harmless, and release Principal from any liability and damages associated with the actions herein described perform by Policyholder as an agent of Principal.

Principal agrees to reimburse the Policyholder for benefits paid in advance. Policyholder will only be reimbursed for days paid that Principal has deemed the employee is eligible for benefits and at the amount the Principal has calculated is due.

The PFML reimbursement will be issued via check separately by employee.

This agreement may be terminated by Principal anytime.

Signature		**Date**	
Name		**Title**	

Employer Signature

By signing this form I declare that all the statements listed are true and completed to the best of my knowledge.

Signature*		**Date***	
Name*		**Title***	
Phone Number*		**Email**	

Disability and Life Waiver Benefits Claim
Attending Physician Statement

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To be completed by your Provider. You can submit claims directly on the web at www.principal.com/FileAClaim or you can complete this form and e-mail or fax it to Principal using the contact information above. Please include office notes and test results from date of disability to present. The patient is responsible for obtaining a complete form without expense to Principal.
If the patient's disability claim includes another coverage (PFML, Critical Illness, Accident, or Hospital Indemnity), a coverage specific Physician Statement is required in addition to the one provided with this form. These are available at www.principal.com.

Patient Information

***Required Field**

Name*		**Date of Birth***	
Reason of Leave (Check one)	☐ Sickness ☐ Pregnancy ☐ Injury ☐ Mental Health		

Medical Information

Diagnosis Codes* (ICD-10)		**Date of Onset or Injury***	
Symptoms			
Patient's employment caused their condition:*	☐ To occur	☐ To worsen (already had condition)	☐ N/A
Is patient competent to endorse checks and direct use of proceeds?*	☐ Yes ☐ No		

Patient Visits and Frequency

First Visit*		**Most Recent**		**Next Scheduled**	
Frequency?	☐ Daily ☐ Weekly ☐ Monthly ☐ Quarterly ☐ Other:				
Patient recently hospitalized?	☐ Yes ☐ No	**Admission Dates**	Start	Through	**Facility Name**
Ever had the same or similar condition?	☐ Yes ☐ No	**If yes, when?**			

Treatment*

Please specify all treatments for this claim

Medications (dose/freq)	
Surgery (CPT-4/date)	
Therapy	
Referrals	

Pregnancy only - Bed Rest and Delivery

Patient prescribed bed rest?	☐ Yes ☐ No	**Dates applicable**	Start	Through	
Date of Delivery (Expected, if not delivered)		**Type of Delivery**	☐ Vaginal	☐ C-Section	

Disability and Life Waiver Benefits Claim
Attending Physician Statement - continued

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Restrictions and Limitations

Pregnancy and Mental Health Claims: Please take note of what information is required for your claim type. Some questions in this section may be skipped when noted.

Work Status

Stop Work Date*		**Stop Work Duration***	☐ Permanent ☐ Return on:
Support return to work with listed limits?	☐ Yes ☐ No	**Support return to work on a part time basis?**	☐ Yes, _____hours/day ☐ No

Physical Impairment* (Skip for Mental Health/Pregnancy Claims)
In a typical workday, your patient is medically restricted to only:

Continuously (C): 6-8 hours of an 8-hour day OR >60 times per hour
Frequently (F): 3-6 hours of an 8-hour day OR 12-60 times per hour
Occasionally (O): <3 hours of an 8-hour day OR 1-12 times per hour
Never (N): Does not perform

	Continuously	Frequently	Occasionally	Never
Sitting	☐	☐	☐	☐
Standing	☐	☐	☐	☐
Walking	☐	☐	☐	☐
Power Grasp	☐	☐	☐	☐
Fine Manipulation	☐	☐	☐	☐
Keyboarding	☐	☐	☐	☐
Lifting	_____lbs	_____lbs	_____lbs	☐

Mental Status Examination (Mental Health Condition Only)

Please check any and all items that apply to the patient's current mental state.

Mood	☐ Euthymic	☐ Anxious	☐ Dysphoric	☐ Depressed	☐ Elevated
	☐ Irritable	☐ Euphoric	☐ Labile		
Affect	☐ Appropriate	☐ Congruent to Mood	☐ Blunted	☐ Flat	☐ Tearful
	☐ Guarded	☐ Inappropriate	☐ Other:		
Sleep	☐ Normal	☐ Disrupted	☐ Hypersomnia	☐ Hyposomnia	☐ Insomnia
	Hours/Night:				
Appetite/ Eating	☐ Weight Loss	☐ Weight Gain	**How Much?**	lbs	**Eating Disorder?** ☐ Yes ☐ No
Grooming/ Dress	☐ Good	☐ Appropriate/Adequate	☐ Poor	☐ Disheveled	
Manner of Speech	☐ Clear	☐ Soft	☐ Loud	☐ Pressured	☐ Incoherent ☐ Slurred

Disability and Life Waiver Benefits Claim
Attending Physician Statement - continued

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(Mental Status Examination, continued)

Psychomotor Activity	☐ Normal Limits ☐ Agitated/Restless ☐ Slowed		
Orientation	☐ Person ☐ Place ☐ Time ☐ Situation		
Concentration	☐ Normal Limits ☐ Fair ☐ Poor	**Memory**	☐ Intact ☐ Impaired
Please explain how concentration and memory was measured, screening tests used, and how the patient's work is affected:			

Please describe all your patient's functional limitations in each area below and how they're affected

Job Duties			
Physical			
Family			
Social			
Daily Living			
Can the patient perform their job for a different employer or supervisor?	☐ Yes ☐ No	**If yes, please explain**	
How will the patient's treatment plan help them return to their work?			
Limitations for the patient to observe when returning to work.			

PFML (Only complete if claim includes PFML with Principal)

Leave is	☐ Continuous ☐ Intermittent	
Estimated frequency they require care	_____ times per	☐ Day ☐ Week ☐ Month
Estimated duration per episode		☐ Hours ☐ Days

By signing this form I declare that all of the statements listed are true and completed to the best of my knowledge.

Signature* (No Stamp)			**Date***	
Physician Name*				**Deg.***
Specialty*		**Phone Number***		ext.
Email			**Fax Number**	
Practice Address	Street			
	City		State	ZIP

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

Administered by
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Attn: Group Life and Disability Claims
PO BOX 14472
Des Moines, Iowa 50306-3472
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I authorize any physician, medical practitioner or other health care professional, hospital, clinic or other medical facility, laboratory, pharmacy, pharmacy benefit manager, 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 within the past 10 years 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 diagnosis, treatment, prognosis, examinations, test results or prescriptions, and may include HIV infection, any disorder of the immune system, including AIDs, sexually transmitted diseases, mental illness (excluding psychotherapy notes as defined under HIPAA) or the use of alcohol, drugs, and tobacco, unless otherwise restricted by state law.

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 coverages, and conduct other legally permissible activities that relate to any coverage I have or have applied for with Principal Life.

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, Workers' 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 third parties that perform functions or services that pertain to 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: Group Life and Disability Claims, Principal Life Insurance Company, PO BOX 14472, Des Moines, IA 50306-3472. 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.

If applicable, I understand that ShelterPoint Life administers New York State Disability Benefits (DBL) and Paid Family Leave (PFL) coverage and/or New Jersey Temporary Disability Benefits (TDB) coverage and DBL/PFL and/or TDB are not subject to HIPAA and information provided to Principal Life may be shared with ShelterPoint to administer any benefits I may be eligible for.

I understand that if I refuse to sign this authorization to release my complete medical record, Principal Life may not be able to evaluate or administer my request for coverage or benefits. Upon my request, a copy of this completed authorization will be provided to me. Any alteration of this form will not be accepted.

Patient's or representative's signature	Date	Claim #	
Patient's full name	Date of birth	Email address	
Employee Address	City	State	ZIP code
Phone 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.

If you are the representative of the patient (including a member acting as a representative on a dependent's behalf) describe the scope of your authority to act on the patient'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

Consent to do Business Electronically with Principal Life Insurance Company

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

This is a consent to do business electronically.

- Your consent applies to documents relating to your claim with Principal Life Insurance Company which are available in electronic format and which you prefer to provide or receive via e-mail. An electronic format may not be available for all types of claims or for all types of documents.
- You are not required to handle any portion of your claim electronically. You can decline to consent to this document and your claim will be handled using paper documents.
- Once you provide your consent, you will have the right at any time to withdraw it.
- We will need your email address in order to communicate and exchange documents electronically. If your email address should ever change, you must notify us and provide updated information.
- You will need access to a computer or device capable of sending and receiving email messages with attachments. You will need an operating system that allows you to download and print documents or save them. You will need Adobe Reader or similar software to view and retain documents in PDF format. If we should ever change the hardware or software requirements needed to access or share documents electronically, we will advise you.
- You will have the ability to download and print any documents we send or make available to you electronically. You may also request delivery of paper copies by contacting us.
- If you decide to withdraw your consent, request paper copies of electronic documents, or report a change in your email address, please contact us at: 800-245-1522.

Agreement - By consenting to do business electronically, you understand and agree that you were able to access and read this information electronically and also were able to print it or save it for your future reference and access.

Member/Claimant Name: _____ **Date of Birth:** _____

Beneficiary Name: _____ **Date of Birth:** _____

Personal Email Address: _____

Signature: _____ **Date**: _____

Printed Full Name: _____

GP62604-00

Authorization Agreement for Electronic Funds Transfer

Administered by
Principal Life Insurance Company
Attn: Group Life and Disability Claims
PO BOX 14472
Des Moines, Iowa 50306-3472
Ph 800-245-1522 Fax 800-255-6609
Email: SBDClaims@principal.com

Principal®

Claimant: _____ Claim number: _____

Please complete this form for the purpose of electronically transferring your periodic income directly into your bank account. Please note, this is not a guarantee of benefits. Benefits are subject to claim approval based on policy provisions.

Bank Information

Bank name | Branch office

Bank phone number | Bank address

City | State | ZIP code

NOTE: Income payments cannot be deposited into an Individual Retirement Account, Investment Brokerage Account, Credit Card, Debit Card, or Pre-paid Card.

Name(s) on account _____

☐ Checking Account ☐ Savings Account

If necessary, contact your bank for this information:

Your Financial Institutions Routing and Transit number: _____

Your Account Number: _____

If the Bank is not able to accept direct deposit a check will be mailed instead.

Authorization Agreement

I Hereby Authorize:

- The Company to initiate credit entries to my account, at the financial institution named above (herein called Bank).
- The Company, if necessary, to initiate debit entries and adjustments to correct any credit entries made in error.
- The Bank to credit and/or debit entries to my account.

This Authorization:

- Applies to any payments that hereafter become due and payable to me under the provisions of the contract(s) identified by the above Account Number.
- This authorization is to remain in full force and effect until Principal Life Insurance Company has written notice from me of its termination.
- I understand and agree that any payment(s) made into an incorrect bank account pursuant to the information reported on this form, will be forfeited by me and that Principal Life Insurance has no obligation to retrieve those funds or make replacement payment(s) to me.

Claimant signature | Joint accountholder signature (if any)

Address

City | State | ZIP code

Phone number | Date

This form may be used for contracts issued by Principal Life. The issuer of the contract should be shown above, and is referred to herein as company.

