Disability Claim Form
Administered by
Principal Life Insurance Company
Attn: Group Life and Disability Claims Department
Des Moines, Iowa 50392-0002

Employer Statement

Instructions

Please mail, FAX, or email this completed form to: Principal Life Insurance Company, Group Life & Disability Claims Department, Des Moines, IA 50392, 1-800-255-6609, dlsbdclaims@exchange.principal.com. Please call 1-800-245-1522 with questions on how to complete this form.

1. This form should be completed **in its entirety** by the employer, the employee/claimant and attending physician.
2. If you have any additional information you feel would help in the review of this claim, please attach to this form.
3. The authorization to release medical information (Page 7) must be completed for all claims and returned with the other sections.

Type and amount of coverage employee is enrolled for with Principal Life Insurance Company.

Life coverage during disability $______ Short term disability $______ Long term disability $______

Does your employee have Long Term Disability coverage with another carrier? yes no

Employee's name ______ I.D. number ______

Employee's address ______ Phone number ______

Employee's job title ______ Date in job ______

Please complete the job description questionnaire on page 2 and send a copy of your employee's job description with this completed form.

Actual hours employee worked per week ______ Date of employment ______

Effective date of employee's coverage ______ Date employee last worked ______

# of hours worked on date last worked ______

Percentage of premium paid by employer* ______% If less than 100%, were premiums paid with employee's pre-tax dollars? post tax?

***See Internal Revenue code Section 105(a) and Regulations thereunder.**

Reason stopped working illness injury other Was coverage in force when disability began? yes no

Has employee returned to work? yes no If yes, give date returned ______ Number of hours ______

Is disability due to employment? yes no If yes, date filed for Worker's Compensation ______

If approved, amount of compensation received $______

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

Name and address of Worker's Compensation carrier (if disability is work related): ______

Employee's salary $______ Salary eff date ______ hourly weekly monthly annually

If salary is not paid hourly, is this a base wage? yes no Does the employee earn any commissions or bonuses? yes no

Any owner/partner salary? If yes, please designate amt or %. ______

If employee not paid by a standard wage, explain how they are paid. ______

Did the claimant have prior STD coverage with another carrier while employed with you? yes no

If yes, date the coverage was effective and name of prior carrier. Effective date: ______ Name: ______

Was salary continued after date last worked? yes no If yes, please provide date salary continuance will be paid thru: ___/___/___

If salary was continued, was the amount paid the same as salary reported? yes no If no, explain: ______

Please specify: salary continuance sick pay vacation PTO other ______

Is employee eligible for or paying into State Disability Income? yes no

If yes, amount received: $______ Effective date: ______

Is employee receiving a pension benefit under a plan sponsored by you, the employer? yes no

If yes, amount received: $______ Effective date: ______

Is employee receiving any income from other sources you are aware of? yes no

If yes, amount received: $______ Effective date: ______ Type of income: ______

Employer name ______ **Plan number** ______ **Unit number** ______

Date ______ **Signature** X ______ **Title** ______

Telephone number ______ **FAX number** ______ **Email address** ______

Job Description Questionnaire

Principal Life has dedicated staff who are available to both employees and employers to assist and answer questions on return to work. Please visit our website at http://www.principal.com/grouplh/return-to-work/index.htm. **We will also be available to discuss the benefits of return to work for you and your employee once the claim is filed.**

Name: ______________________ Job title: ______________________

1. **A regular work day consists of** _______ **hours a day,** _______ **days a week.**

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

2. **Sitting** ________ hours at one time. ________ hours during a regular work day.
   Standing ________ hours at one time. ________ hours during a regular work day.
   Walking ________ hours at one time. ________ hours during a regular work day.

Never – not applicable
Occasionally – up to 3 hours in an 8-hour day or 1-12 times per hour
Frequently – 3-6 hours in an 8-hour day or up to 12-60 times per hour
Continuously – 6-8 hours in an 8-hour day or 60 times per hour

3.	Never	Occasionally	Frequently	Continuously
Lifting		lbs.	lbs.	lbs.
Carrying		lbs.	lbs.	lbs.

4. **Hand Use**	N	O	F	C		N	O	F	C
Simple grasping (left)	☐	☐	☐	☐	Simple grasping (right)	☐	☐	☐	☐
Power grasping (left)	☐	☐	☐	☐	Power grasping (right)	☐	☐	☐	☐
Pushing & pulling (left)	☐	☐	☐	☐	Pushing & pulling (right)	☐	☐	☐	☐
Fine manipulation (not keyboarding)	☐	☐	☐	☐	Keyboarding w.p.m. ________	☐	☐	☐	☐

5. **Reaching**	N	O	F	C		N	O	F	C
At shoulder level	☐	☐	☐	☐	Above shoulder level	☐	☐	☐	☐
At waist level	☐	☐	☐	☐	Below waist level	☐	☐	☐	☐

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

7. **Using feet for repetitive movements as in operational functions:**
   left ☐ yes ☐ no **right** ☐ yes ☐ no **both** ☐ yes ☐ no

8. **Environment**	yes	no	If yes, please describe.
Unprotected heights	☐	☐	
Being around moving machinery	☐	☐	
Exposure to marked changes in temperature and humidity	☐	☐	
Exposure to dust, fumes and gases	☐	☐	
Uses vibrating equipment	☐	☐	
Walks on uneven terrain	☐	☐	
Travels for work (if yes, by what means and how often)	☐	☐	

9. **Technology**	yes	no	If yes, please describe.
Operate automotive equipment (truck, forklift, etc.)	☐	☐	
Office equipment (computer, 10-key, FAX, etc.)	☐	☐	
Computer knowledge (software, E-mail, internet, etc.)	☐	☐	

10. **Remarks (Please add any additional requirements.)**

____

____

11. If the Attending Physician for the employee listed above releases him/her will you be able to:
    Accommodate part time work? ☐ yes ☐ no ☐ possibly
    Accommodate light duty work? ☐ yes ☐ no ☐ possibly

Employer signature: X ____________________ **Title:** ____________ **Date:** ________

Please print name: ____________________ **Phone number:** ____________

Attending Physician's Statement

This completed form may be faxed to Principal Life at 1-800-255-6609.

To Be Completed By Physician – Please include office notes and test results from date of disability to present.

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of employees or their family members. In order to comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information.

Patient's name		Date of birth	Social Security No.
Height	Weight	Blood Pressure (last visit)	

1 Patient is/was unable to work due to : ☐ Injury ☐ Illness ☐ Pregnancy

2 Diagnosis:

ICD-9 Diagnosis Code(s):

3 List any complications your patient is experiencing:

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

5 Subjective Symptoms

6 When did symptoms first appear or accident happen?

7 Is this condition due to injury or illness arising out of patient's employment? ☐ yes ☐ no

8 Did this condition already exist and become exacerbated by employment? ☐ yes ☐ no

Please explain:

9 Is patient competent to endorse checks and direct the use of those proceeds? ☐ yes ☐ no

10 Date of first visit	**11** Date of last visit	**12** Date of next visit	**13** Frequency of visits

14 Has your patient been hospitalized? ☐ yes ☐ no

From: To: Hospital name/number:

15 Has your patient ever had the same or similar condition? ☐ yes ☐ no If yes, when

16 **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:

17 **PREGNANCY CLAIMS ONLY**

What is the expected date of delivery?	Date First Treated	Date Last Treated	Date of Delivery

Bed confined? ☐ yes ☐ no If yes, date began

From: To:

If patient has delivered, type of delivery ☐ Vaginal ☐ C-Section

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

18 MENTAL IMPAIRMENT (if applicable) Provide 5 AXIS Diagnosis

I

II

III

IV

V

Please define “stress” as it applies to your patient:

Could your patient perform his/her job if it was for a different employer/supervisor? ☐ yes ☐ no

19 CARDIAC (if applicable)

If this is a cardiac condition, what is the functional capacity? (American Heart Association) ☐ C1 ☐ C2 ☐ C3 ☐ C4

20 PHYSICAL IMPAIRMENT

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	☐	☐	☐	☐

Please provide any additional restrictions and limitations not specified above, including other factors that may affect employment activities:

PROGNOSIS:

Have you advised your patient to restrict employment activities? ☐ yes ☐ no

If yes, beginning on what date? ____________________

Have you discussed your patient’s job duties? ☐ yes ☐ no

Has your patient been released to return to work? ☐ yes ☐ no If yes, please provide date ____________________

If the employer can accommodate the patient’s limitations, do you support return to work at this time? ☐ yes ☐ no

If the employer can accommodate part-time work, do you support return to work at this time? ☐ yes ☐ no

If yes, how many hours per day? ____________________

If your patient has not been released to return to work, please provide an estimated return to work/recovery date. ____________________

Please explain if this date falls beyond the typical recovery time for this diagnosis.

21 Physician Name (Please Print) | **Degree**

Specialty | **Phone Number** | **FAX Number**

Address | **City** | **State** | **Zip Code**

Please provide a contact name for additional questions.

Signature (No Stamp)
X
| **Tax ID Number** | **NPI Number** | **Date**

Employee Statement

The Employee Statement must be accompanied by the Authorization for Release of Personal Health and other Information found on page 7

Your name ______ Date of birth ______ Soc Sec # ______

Your home address ______
(Street) (City) (State) (ZIP code)

Home telephone number ______ Work telephone number ______ Gender male female

Cellular telephone number ______ Your email address ______

Date you became disabled ______ Is disability due to accident illness Please describe accident in detail, Including date, time and place of occurrence. If illness, nature of illness and date ______

If disability is the result of a motor vehicle accident, have you applied for or are you receiving No Fault/Auto Insurance Income Replacement benefits?
yes no If yes, date applied ______ Amt received $ ______ Freq of pmts ______

Please include a copy of the police report and the auto agent's carrier name, phone number and policy number: ______

Did disability result from employment? yes no Have you filed a Worker's Compensation claim? yes no

If yes, date filed for Worker's Compensation ______ If approved, amount received $ ______ Freq of pmts ______

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

Do you have other insurance with our company? yes no If yes, please list policy numbers: ______

Do you have other disability insurance with other companies? yes no If yes, provide the following:

Name of company	Policy number/policy date	Benefit amount received per month

Is the coverage listed above: Group coverage Individual coverage

Indicate if you have applied for or are receiving any of the following benefits, date applied and benefit amount if approved (please send copy of award letter or most recent **benefit** check stub.)

Type	Date Income Began	Amount	Type	Date Income Began	Amount
Social Security Disability/Retirement/Widows			State Disability		
Social Security Early Retirement			Pension		
Unemployment			Other Income		

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

List the number of hours you spend each day in the following activities **while working**:

Sitting ______hrs/day Walking ______hrs/day Lifting ______hrs/day Average weight lifted ______lbs

Standing ______hrs/day Traveling ______hrs/day Bending ______hrs/day Maximum weight lifted ______lbs

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

I declare that all the above statements on this form are true and complete to the best of my knowledge.

X ______ ______
(Signature of employee) **(Date)**

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

______ X ______ ______
(Country) **(Signature)** **(Date)**

This completed form may be faxed to Principal Life at 1-800-255-6609.

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 **accident and health** 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.

X ______________________________ ______________________________

(Claimant's Signature) **(Date Signed)**

Notice Requirements

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.

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.

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

I authorize any physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, health care provider, health plan 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: 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: X ______________________ **Date:** ______________

Claimant's full name: ______________________ **Date of birth:** ______________

Claimant's address: ______________________________________

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

Incident number: ______________________________________

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:

______________	X ______________	______________
(Country)	**(Signature)**	**(Date)**