Accidental Dismemberment / Personal Loss Claim Select...

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

Principal®

Statement of Employer

Employee's name (first, middle, last) (Please list all names member may have been known by such as maiden name, nickname or alias.)

I.D. number | Unit or division number

Benefit class | Effective date of coverage | Effective date of last change

Was employee in your employ when loss occurred? ☐ yes ☐ no Date employee entered employment

Was coverage in force when loss occurred? ☐ yes ☐ no Date employee last worked

Is employee's coverage still in force? ☐ yes ☐ no If "no", give date of termination

Has employee returned to work? ☐ yes ☐ no If "yes", give date returned

Employee's salary: Monthly $ | Weekly $ | Hourly $ | Number of hours per week | Effective date of salary

Amount of benefit claimed | Plan number

Employer

By (signature) ▶ | Title | Date

Telephone number | FAX number

Instructions to Employee

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

(1) This form is to be filed promptly after the accident for which claim is made has occurred.

(2) Complete the **Statement of Employee** below. A completed authorization for release of information (GP 49771) must accompany this form.

(3) A Consent to do Business Electronically with Principal Life Insurance Company is on page 6 and may also be completed and returned with the claim form at your option. Please see the form for details. **NOT AVAILABLE FOR USE IN CALIFORNIA.**

(4) Have your physician complete the Attending Physician's Statement on Page 2 and Page 3.

(5) Mail or FAX the completed form to Principal Life Insurance Company at the address given at the top of this page.

Statement of Employee

Your name | Social security number | Date of birth

Telephone number | Your occupation | Did loss result from employment? ☐ yes ☐ no

What was loss for this claim? | When did loss occur: Date | Hour ☐ a.m. ☐ p.m.

Describe accident causing loss (give date, plan, etc.)

Have you been hospital confined? If yes, when: from/to ☐ yes ☐ no | Your doctors during the past year | Sickness or injury | Date consulted

Name of hospital

Hospital address

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.

These statements are true and complete to the best of my knowledge. ▶ Signature of employee | Date

Address of employee (street number, city, state, ZIP code)

Is this a new address? ☐ yes ☐ no | Please furnish a daytime telephone number in case we need to reach you.

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ACCIDENTAL DISMEMBERMENT / PERSONAL LOSS CLAIM

Attending Physician's Statement

Patient's name

Date you first attended patient | Date you last attended patient

Has loss resulted in permanent, complete and irreversible loss of voluntary movement?

Describe accident causing loss.

Has patient been hospital confined? ☐ yes ☐ no | If yes, give name of hospital

Date confined from/through | Address of hospital

Nature of surgery, if any (give date).

Date loss occurred | Did loss result from employment? ☐ yes ☐ no

Did any sickness, disease, or prior injury contribute to loss? ☐ yes ☐ no

If "yes", explain.

Loss of Hand or Foot Due to Severance

Is severance at or above the wrist or ankle? ☐ yes ☐ no

Comments:

Loss of Thumb and Index Finger

Is the loss on the same hand? ☐ yes ☐ no

Comments:

Loss of Sight

What is the current visual capacity in the injured eye, compared to the previous capacity?

To what degree can color, objects, or movement be distinguished with the injured eye?

What is the injury's effect on binocular vision?

Is the loss permanent? ☐ yes ☐ no

To what degree is the impairment correctable with glasses or future surgery?

Comments:

ACCIDENTAL DISMEMBERMENT / PERSONAL LOSS CLAIM

Attending Physician's Statement (continued)

Loss Due to Paralysis

Has the loss resulted in permanent, complete and irreversible loss of voluntary movement?

Has the loss continued for at least 12 consecutive months?

Is the loss a result of a stroke?

Loss of use is:

- ☐ Quadriplegia
- ☐ Paraplegia
- ☐ Both hands or both feet
- ☐ One hand and one foot
- ☐ One arm or one leg
- ☐ One hand or one foot

Comments:

Loss of Speech or Hearing

Is the loss

- ☐ Speech
- ☐ Hearing in both ears
- ☐ Hearing in one ear

Is the loss permanent, complete and irreversible?

Has the loss continued for at least 12 consecutive months?

What is the current level of functioning compared to pre-injury status?

For hearing loss, please include audiograms.
For speech loss, please include speech therapy assessment.

To what degree is the impairment correctable by future surgery, devices or medication use?

Comments:

Print: Physician's name	Degree	Specialty	Telephone
Street address	City	State or province	ZIP code

Physician's signature ▶	Date	Tax identification number

Notice Requirements

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, 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 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.

Authorization for Release of Personal Health and Other Information to 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
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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 the Principal Life Insurance Company (Principal Life), its agents, employees, insurance support organizations, reinsurers, and their representatives. This includes information on the diagnosis, treatment and/or testing results related to HIV, AIDs, sexually transmitted diseases, 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: _____ **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.

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)

Consent to do Business Electronically with Principal Life Insurance Company

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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 contacts 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: _____

Signature:

Email:

