Group Life 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

Instructions to Beneficiary

(Use this form for both member and dependent claims.)

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) Complete Part II, Part III and Part IV of the form.

The following information may help you.

More than one beneficiary – If more than one beneficiary is named, each beneficiary needs to complete a claim form.

Member's estate as beneficiary; minor/incompetent beneficiary; predeceased beneficiary - If the life benefit is determined to be due and payable to any of these beneficiaries, there may be additional information required in order to release the benefit. A company representative will contact you to request information when appropriate.

Additional information - Principal Life reserves the right to require and obtain such statements, authorizations and other information as it deems necessary to determine what benefits are payable on any claim.

(2) If accidental death/personal loss benefits are being claimed, the following information may be needed. Please provide any of these documents you may already have:

- Incident Report
- Autopsy/toxicology reports
- Newspaper clippings
- Investigating police department and contact name and phone number
- If member's death occurs more than 100 miles from permanent place of residence and costs are incurred for preparation and transportation of the body, please enclose a copy of the associated expenses.
- The policy may provide additional accidental death/personal loss benefits if the member has "Qualified Students." A "Qualified Student" is a dependent child who is, at the time of death, a full-time student at an accredited post-secondary school or a 12th grade student if he/she enrolls in an accredited post-secondary school within 12 months of death. If there is a "Qualified Student," please call the 800 number listed above to determine if additional benefits are applicable and to obtain the necessary form to apply for this benefit. (This benefit not approved in some states.)
- Complete attached authorization page and return with the other documents requested.
- 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.**

(3) Attach a certified copy of the deceased member's (dependent's) death certificate. If the death occurred outside the United States, attach a copy of document entitled "Death of an American Citizen" from the U.S. Embassy.

(4) Return the completed form and death certificate to the group planholder.

Instructions to Group Planholder

(1) Complete Part I of this form accurately and completely to avoid any delays in payment of the benefits.

NOTE - If more than one beneficiary is named, you must provide a form to each beneficiary for completion of Part II and Part III of the form. You need not complete Part I on all the forms. If possible, please submit all claim forms at the same time.

(2) Return the completed form(s) and any other information you may have, such as:
(a) enrollment forms, (b) change of beneficiary forms, (c) assignments, (d) settlement instructions to:

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Life Claim Information

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Principal®

Part I: Information about the Group Planholder

Member's name (Please list all names member may have been known by such as maiden name, nickname or alias) | Member's I.D.

If dependent death, name | Relationship to member

Member's job title | Member's classification in policy | Salary $ | Effective date of salary

Effective date of member's coverage | Date member began employment | Number of hours worked per week | Date member was last physically at work

Reason member ceased active work:
retired illness or injury terminated death other (explain) _____

Were premiums paid through date of death? yes no

If dependent claim, was member working at the time of death? yes no

If no, what was the date last worked? _____ If dependent, is member still working? yes no

Did the member name more than one beneficiary? yes no If yes, are all claim forms attached? yes no

Amount of benefit claimed
$

Employer name | Policy number | Unit/division number

Signature of planholder ▶ | Title | Date

If we have questions, your phone number is | Email Address | FAX number

GROUP PLANHOLDER: please return to Principal Life

Part II: Information about the Deceased

Deceased's name

Address – street | City | State | ZIP

Date of birth | Date of death | Social security number

Was member (dependent) insured under any other policies with other companies? yes no

If yes, give name of company and amount of insurance: _____

Was dependent employed? yes no If yes, please give employer's name, phone number and date last worked.

Did member (dependent) have other coverage with Principal Life? GUL Individual Group Pension

Part III: Information about the Beneficiary

Your name (beneficiary) | Date of birth

Your address – street | City | State | ZIP

Your phone number – home | Your phone number - work | Main Contact/Personal Email Address

You are making claim to:
☐ all of the proceeds on the deceased's claim.
☐ only the portion due me as one of the beneficiaries of the member.

Your relationship to member: ☐ spouse ☐ child ☐ other (explain) _____

Part IV: Settlement Information

Complete Part IV if you are a U.S. citizen or other U.S. person including a resident alien, or domestic trust or estate. Otherwise, leave blank and complete and provide Form W-8BEN (foreign individuals) or Form W-8BEN-E (foreign entities) and submit with this form. These forms can be found on the IRS website at www.irs.gov/.

Request for Taxpayer's Social Security Number or Tax Identification Number and Certification.

If the social security number or tax identification number of the beneficiary is not supplied, the beneficiary may be subject to federal and state tax withholding. I have provided the appropriate social security or tax identification number below:

☐ The benefits are being claimed by me as a beneficiary and my social security or tax identification number is

_____

☐ The benefits are being claimed by the legal guardian of a minor/incompetent person's estate.
The minor/incompetent person's social security number is _____

☐ The benefits are being claimed by a trustee of a trust or a personal representative of an estate.
The tax identification number for the trust or estate is _____

Under penalties of perjury I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and
3. I am a U.S. citizen or other U.S. person (as defined in the instructions), and
4. I am exempt from FATCA reporting.

Certification instructions: You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. See the IRS website (www.irs.gov) for instructions in completing Form W-9.

The information provided by me on this claim form is true and complete to the best of my knowledge.

The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.

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.

Date

Signature of beneficiary (Please make sure you sign form as your name appears on your social security card.)

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.

Group Life 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, emergency care provider, 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 the deceased insured to disclose the entire medical, accident, and medical examiner records to Principal Life Insurance Company, 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 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, accident 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 medical, life, and disability coverages, and conduct other legally permissible activities that relate to any coverage 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 the deceased insured's employment, employment history or income to Principal Life.

The following groups of persons employed or working for Principal Life may use 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 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: Life/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 complete medical, accident or medical examiner records, Principal Life may not be able to process the 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.

Deceased's name: _____ **Deceased's date of birth:** _____

Representative's signature: _____ **Date:** _____

Representative's full name: _____ **Date of birth:** _____

Representative's address: _____

Representative's Main Contact/Personal Email: _____

Representative's telephone number: _____

Can confidential messages be left at this number? yes no

Representative's relationship to the deceased: _____

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:

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