



Administered by
Principal Life Insurance Company
Des Moines, Iowa 50392-0002

Disability Claim Form - FL

Instructions

- If you have questions concerning completion of this form, please contact Group Life and Disability Claims at 1-800-245-1522.
Please mail or FAX this completed form to: Principal Life Insurance Company, Group Life & Disability Claims Department, Des Moines, IA 50392, 1-800-255-6609.
1. This form should be completed in its entirety by the employer, the insured/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 5) must be completed for all claims and returned with the other sections.
4. Please include a photocopy of the insured/claimant's driver's license or other photo ID.
5. If disability is due to an auto accident, include a copy of the police report and provide the auto agent's carrier name and phone number.

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.

Employer Statement

Type and amount of benefit being claimed (please fill in all that apply):

Life coverage during disability \$ Short term disability \$ Long term disability \$
Employee's name I.D. number
Employee's address Phone number
Employee's job title Date in job
Employee hours worked per week Date of employment
Effective date of employee's coverage Date employee last worked
of hours worked on date last worked Please describe specific job duties or attach a copy of job description:

Percentage of premium paid by employer* % If less than 100%, were premiums paid with employee's pre-tax dollars? yes no

*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 \$ hourly weekly monthly annually
Salary eff date Any owner/partner salary? If yes, please designate amt or %.
If employee not paid by a standard wage, explain how they are paid.
Was salary continued after date last worked? yes no If yes, please provide date salary continuance did/will end:
If salary was continued, was the amount paid the same as salary reported? yes no If no, explain:
Is employee receiving State Disability Income? yes no If yes, amt received \$ Eff date
Is employee receiving a pension benefit under a plan sponsored by you, the employer? yes no
If yes, amt received \$ Eff date
Is employee receiving any income from other sources you are aware of? yes no
If yes, amt received \$ Eff date

Type of income
Employer name Plan number Unit number
Date By Title
(signature)
Telephone number FAX number

Employee Statement (Must be accompanied by the Authorization for Release of Personal Health and other Information on Page 5)

Your name _____ Date of birth _____ Soc Sec # _____

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

Home telephone number _____ Work telephone number _____

Cellular telephone number _____ Date you became disabled _____

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	Type of coverage	Benefit amount received per month
_____	_____	_____	_____
_____	_____	_____	_____

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 provide name, address, phone number and policy number of your auto insurance carrier: _____

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

If no, please explain: _____

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.)

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.)

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

Please list current or past employers and occupations within the past 2 years from the date disability began (use a separate sheet if necessary).

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

List the number of hours spent each day in the following activities:

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	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.

 (Signature of employee)

 (Date)

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

DISABILITY CLAIM FORM

Attending Physician's Statement (page A). Please fully complete this form. If incomplete, we will call for omitted information.

Patient's name _____ Social security number _____ Date of birth _____

Physician's name (please print) _____ Degree _____ Specialty _____

Physician's street address _____

City _____ State or providence _____ ZIP code _____

Tax ID number _____ Physician's phone number _____ Physician's FAX number _____

DIAGNOSIS

ICD-9 diagnosis code: _____ Blood pressure reading _____ / _____ Date of reading _____
Diagnosis (including any complications) _____ Patient's height _____ Patient's weight _____

If disability is due to pregnancy, what is expected or was the delivery date? _____ vaginal delivery
 caesarean section

Please describe any complications that would extend this disability longer than a normal pregnancy:

Subjective symptoms

Objective findings (including current x-rays, EKG's, laboratory data and any clinical findings)

Is patient ambulatory? house confined? bed confined? hospital confined?

Do you believe the patient is competent to endorse checks and to direct the use of those proceeds? yes no

Is condition due to injury or sickness arising out of patient's employment? yes no

HISTORY

What date did symptoms first appear or accident happen? _____

Has patient ever had same or similar condition? yes no

If yes, please provide dates and describe past treatment, including any surgical procedures:

NATURE OF TREATMENT (Including any type and date of surgery and medications prescribed if applicable) CPT-4 code: _____

Date of first visit _____ Date of last visit _____ Date of next visit _____

Frequency of visits weekly monthly other (specify) _____

Has patient been hospitalized? yes no If yes, name and address of hospital and date(s) of confinement:

CARDIAC (if applicable)

Functional capacity (American Heart Association) class 1 (no limitation) class 2 (slight limitation)

class 3 (marked limitation) class 4 (complete limitation)

METS (circle one) 1 2 3 4 5 6 7

OTHER PHYSICIAN INFORMATION

Was the patient referred to you by, or by you to, another physician? yes no If yes, please provide name and address of other physician:

Physician's name _____ Address _____

PHYSICAL IMPAIRMENT (*as defined in Federal Dictionary of Occupational Titles)

- class 1 – no limitation of functional capacity; capable of heavy work* no restrictions (0-10%)
- class 2 – medium manual activity* (15-30%)
- class 3 – slight limitation of functional capacity; capable of light work* (35-55%)
- class 4 – moderate limitation of functional capacity; capable of clerical/administrative (sedentary*) activity (60-70%)
- class 5 – severe limitation of functional capacity; incapable of minimal (sedentary*) activity (75-100%)

Remarks: _____

MENTAL/NERVOUS IMPAIRMENT (if applicable)

- class 1 – patient is able to function under stress and engage in interpersonal relations (no limitations)
- class 2 – patient is able to function in most stress situations and engage in most interpersonal relations (slight limitations)
- class 3 – patient is able to engage in only limited stress situations and engage in only limited interpersonal relations (moderate limitations)
- class 4 – patient is unable to engage in stress situations or engage in interpersonal relations (marked limitations)
- class 5 – patient has significant loss of psychological, physiological, personal and social adjustment (severe limitations)

Please define "stress" as it applies to this claimant.

What stress and problems in interpersonal relations has claimant had on the job?

Remarks: _____

PROGNOSIS

Does the patient's condition restrict employment activities? yes no

If yes, beginning on what date _____ end date _____

In an 8 hour day, patient can (restrictions/limitations):

Sitting _____ hrs/day Walking _____ hrs/day Lifting _____ lbs/max Bend/squat _____ hrs/day
 Standing _____ hrs/day Traveling _____ hrs/day Pushing/pulling _____ hrs/day Crawl/climb _____ hrs/day

Explain the specific restrictions and limitations, including any other factors that may affect employment activities:

When will patient recover sufficiently to return to work:

1 month 1-3 months 4-6 months on _____ never

If never, please explain: _____

REHABILITATION

Can present job be modified to allow the patient to work with impairment? yes no

If yes, please explain: _____

Is patient a suitable candidate for medical rehabilitation (i.e. cardiopulmonary program, speech therapy, etc.) yes no

Is patient a suitable candidate for vocational rehabilitation? yes no

If yes, what specific restrictions and limitations would you place on vocational rehabilitation?

Date trial employment could begin? **PATIENT'S JOB** full-time part-time _____

Date trial employment could begin? **ANY OTHER JOB** full-time part-time _____

Signature of physician _____ Date _____

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



**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 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 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, worker's 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: _____

Claimant's full name: _____ Date of birth: _____

Claimant's address: _____

Telephone number: _____

Claim 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.