Instructions to Apply for Leave Due to a Serious Health Condition

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®

Applying for Paid Medical or Family Leave Benefits

The attached forms are required to be completed to apply for your leave. These forms must be completed in their entirety by your employer and you.

1. ☐ Your employer needs to complete the Employer Statement on page 2.
2. ☐ You need to complete and sign the Employee Statement, located on page 3
3. ☐ Health Care Provider needs to complete page 4
4. ☐ 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.**
5. ☐ **Once all sections of this form are completed,** please submit to Principal by mail, fax or email.

Group Life and Disability Claims Department
Des Moines, Iowa 50392-0002
Call: 800-245-1522 **Fax:** 800-255-6609
Email: SBDClaims@principal.com

To avoid unnecessary delays, be sure all parts of the application are completed according to the instructions listed above. Once forms are received, we will be able to begin our evaluation.

If you have any questions about your application, please call 800-245-1522 between the hours of 7:30 am and 5:00 pm CST.

What to Expect Once You Submit Your Application for Leave

After your application is submitted, a claims specialist may need to gather any additional information from you, your employer or Health Care Provider. If your request for Leave is approved, the payments are typically paid weekly.

Eligibility Information

You must notify your employer at least 30 days before the start of the leave, if foreseeable, otherwise notify your employer as soon as possible.
You have earned the required amount to qualify for a benefit.

Serious Health Condition Employer Statement

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To be completed and signed by the employer

Employee's name:	Phone Number:	DOB:	
Employee's address:	City:	State:	Zip Code:
Social Security Number:	Employee's job title:	I.D. number:	

Work Schedule: Please provide number of scheduled hours to work each day

Monday _____
Tuesday _____
Wednesday _____
Thursday _____
Friday _____
Saturday _____
Sunday _____

In the preceding 52 weeks has the employee taken leave for :

Disability ☐ Weeks _____ Days _____ (specific dates)

Paid Medical or Family Leave ☐ Weeks _____ Days _____ (specific dates)

None ☐

Is the condition Work Related? ☐ Yes ☐ No Has a Workers' Compensation Claim been filed? ☐ Yes ☐ No

Employment Status

Date of Employment: _____ Date Last Worked _____ Date Returned to Work _____

State employee works in? _____

If no longer employed, date of termination: _____

Is the leave for your employee ☐ or to care for a family member ☐

Financial Information

Employee base salary: $ _____

Salary effective date: _____

Will the employee receive any type of pay for time after the Date Last Worked? ☐ Yes ☐ No

If yes: Is the employee receiving full pay:

☐ Yes, Date paying through: _____

☐ No, please explain amounts: _____

Employer Name: _____ **Plan Number:** _____ **Unit Number:** _____

Date: _____ **Signature:** X _____ **Title:** _____

Telephone Number: _____ **FAX Number:** _____ **Email Address:** _____

Serious Health Condition Employee Statement

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

Name: _____ Date of Birth: _____ Gender: Male ☐ Female ☐ Non-Binary ☐

Social Security #: _____ Street Address: _____

City: _____ State: _____ Zip Code: _____ Email Address: _____

Phone Number: _____ Home: ☐ Cell: ☐ Work: ☐ What's your Preferred Language? _____

Name of employer:

Is the leave for your own Serious Health Condition? ☐ Yes ☐ No ; if no provide the relationship of who the care is for. _____

Will Medical or Paid Family Leave (PFL) be for a continuous period of time or periodic?

☐ Continuous Start Date: _____ End Date: _____

☐ Periodic Identify dates periodic leave will be taken: _____

Other benefits you have applied for or are receiving: Unemployment ☐ Social Security (Disability) ☐ Workers' Compensation ☐

Date income began: Amount: $

I give permission to accept text messages about my claim: ☐ Yes ☐ No **If Yes**, phone number: _____

Name of your cell phone provider: _____ **Standard text-message and data rates may apply.**

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.

Signature: X	**Date:**

Health Care Provider Statement for Serious Health Condition

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Medical Certification (to be completed by a Health Care Provider)

Questions 1-7 are information for the employee

1. Employee Name: _____
2. Date of Birth: _____
3. Social Security #: _____
4. Is leave for a continuous or intermittent period of time: _____
5. Start date of leave: _____
6. Estimated end date of leave: _____
7. Return to work date: _____
8. Patients Name: _____ Relationship to patient: _____ Patients DOB: _____
9. If the leave is for someone other than the employee, does the patient require care by this employee. ☐ Yes ☐ No
10. Indicate what serious health condition the patient has

☐ Inpatient care (i.e., an overnight stay) in a hospital, hospice, or residential medical care facility.
Facility Name: _____ Date of admission: _____ Date of discharge: _____

☐ Permanent or long-term condition for which the patient is under continuing supervision of a health care provider but for which treatment may not be effective (e.g., Alzheimer's, a severe stroke).

☐ Out of work to undergo multiple treatments and related recovery for one of the below:
(1) restorative surgery after an accident or other injury or
(2) a condition that would likely result in a period of incapacity of more than three (3) full, consecutive calendar days in the absence of such treatment.

☐ A chronic health condition which continues over an extended period of time and BOTH:
(1) requires periodic visits for treatment by a health care provider (at least two (2) visits per year) and
(2) may cause episodic incapacity or flare-ups or would cause periods of reoccurrence without treatment (e.g. asthma, diabetes, epilepsy, etc.).

☐ Pregnancy or prenatal care.

☐ Incapacity and Treatment:
(1) treatment 2 or more times within 30 calendar days of the first day of incapacity; or
(2) treatment on at least one occasion which results in a regimen of continuing treatment; or

11. If the employee has a serious health condition is it medically necessary for them to miss work? ☐ Yes ☐ No
12. If question 10 is yes, please identify the job function(s) the employee is unable to perform.

_____

_____

13. Primary ICD 10 Code: _____
14. Diagnosis: _____

Medical Certification (to be completed by a Health Care Provider) - continued

15. Date patient's condition began: _____

16. Expected date patient will no longer require care: _____

17. Estimated time per week the patient requires care:
Hours per day _____ Days per week _____

18. Date of first visit: _____

19. Date of last visit: _____

20. Date of next visit: _____

21. Frequency of visits: _____

22. Is patient competent to endorse checks and direct the use of those proceeds? ☐ Yes ☐ No

22. **Physician Name (Please Print)** _____ **Degree** _____

Specialty _____ **Phone Number** _____ **Fax Number** _____

Address _____ **City** _____ **State** _____ **Zip Code** _____

Tax ID Number: **NPI Number:**

I certify the answers I have made to the above questions are complete and true to the best of my knowledge and belief.

Signature (No Stamp) **X** **Date**

Consent to do Business Electronically with Principal Life Insurance Company

Administered by **Principal Life Insurance Company**
Attn: Group Life and Disability Claims Department
711 High Street
Des Moines, Iowa 50392-0002
Toll free Nationwide 800-245-1522
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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: _____

GP62604-00

Authorization Agreement for Electronic Funds Transfer

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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 telephone 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.

☐ 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.

On a separate page please attach a voided check or the Direct Deposit information on your Financial Institutions Letterhead or similar paperwork

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

Telephone 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.

Print