

Instructions to Apply for Leave to Care for a Covered Service Member or Qualifying Exigency

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



Applying for Paid Family Leave Benefits

The attached forms are required to be completed to apply for your family leave benefits. These forms must be completed in their entirety by your employer and you. If the leave is to care for a Covered Service Member the medical certification must be completed by a Health Care Provider.

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. ☐ If your leave is for a Covered Service Member, The Patients Health Care Provider needs to complete page 4
4. ☐ If your leave is for a Qualifying Exigency you must submit one of the documents listed on page 5
5. ☐ 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.**
6. ☐ **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 these Claim Forms are completed according to the instructions listed above. Once forms are received, we will be able to begin our evaluations.

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

What to Expect Once You Submit Your Claim Request for Leave

After your claim 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.

Care for a Covered Service
Member or Qualifying Exigency
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	<input type="checkbox"/>	Weeks _____ Days _____	(specific dates)
Paid Family Leave	<input type="checkbox"/>	Weeks _____ Days _____	(specific dates)
None	<input type="checkbox"/>		
Employment Status			
Date of Employment: _____ If no longer employed, date of termination: _____			
State employee works in? _____			
Is the leave for your employee <input type="checkbox"/> or to care for a family member <input type="checkbox"/>			
Financial Information			
Employee base salary: \$ _____			
Salary effective date: _____			
Will the employee receive any type of pay for time after the Date Last Worked? Yes <input type="checkbox"/> No <input type="checkbox"/>			
If yes: Is the employee receiving full pay:			
<input type="checkbox"/> Yes, Date paying through: _____			
<input type="checkbox"/> No, please explain amounts: _____			
Employer Name: _____		Plan Number: _____	Unit Number: _____
Date: _____	Signature: <u>X</u>	Title: _____	
Telephone Number: _____		FAX Number: _____	Email Address: _____

Care for a Covered Service
Member or Qualifying
Exigency
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 <input type="checkbox"/> Female <input type="checkbox"/> Non-Binary <input type="checkbox"/>	
Social Security #: _____ Street Address: _____	
City: _____ State: _____ Zip Code: _____ Email Address: _____	
Phone Number: _____ Home: <input type="checkbox"/> Cell: <input type="checkbox"/> Work: <input type="checkbox"/> What's your Preferred Language? _____	
Name of employer: _____	
Do you have more than one employer? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Is your leave for: Qualifying Exigency <input type="checkbox"/> or to care for a Covered Service Member <input type="checkbox"/> Provide your relationship to the Service Member _____	
What is the Underlying reason for the Exigency Leave? _____	
Will Paid Family Leave be for a continuous period of time or periodic?	
<input type="checkbox"/> Continuous Start Date: _____ End Date: _____	
<input type="checkbox"/> Periodic Identify dates periodic Paid Family Leave will be taken: _____	
Other benefits you have applied for or are receiving: Unemployment <input type="checkbox"/> Social Security (Disability) <input type="checkbox"/> Workers Compensation <input type="checkbox"/>	
Date income began: _____ Amount \$ _____	
I give permission to accept text messages about my claim: Yes <input type="checkbox"/> No <input type="checkbox"/> 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 Care for a
Covered Service Member

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

1. Patient Name: _____
2. Date of Birth: _____
3. Social Security #: _____
4. Employee Name: _____ Relationship to Patient: _____
5. Does the Patient require care by the Employee requesting Paid Family Leave: Yes ☐ No ☐
6. Primary ICD 10 Code: _____
7. Diagnosis: _____
8. Is the patients Serious Health Condition connected to their military service: _____
9. Date patients condition began: _____
10. Date the Employee will need to begin caring for the patient : _____
11. Expected date patient will no longer require _____
12. Estimated number of days per week patient requires care: _____

13.	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 _____	

Qualifying Exigency Documentation

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Attach the needed documents as noted below to satisfy the required evidence of a Qualifying Exigency.

- ☐ a copy of the Family Member's active duty orders; or
- ☐ a letter of Impending Activation from the Family Member's Commanding Officer; or
- ☐ other documentation reasonably acceptable to Principal Life in circumstances where, for good cause shown, the Covered Individual is unable to produce the documentation specified above; and
- ☐ a statement of the family relationship between the service member and the Covered Individual.

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
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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 contact 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: _____

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.