Instructions for Applying for Leave to bond with a newly born, adopted or fostered child

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 Family Leave Benefits

The attached forms are required to be completed to apply for your bonding benefits through our claims process. 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. ☐ A Consent to do Business Electronically with Principal Life Insurance Company is on page 5 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. ☐ **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 Bonding Leave

After your claim is submitted, a claims specialist may need to gather any additional information from you and your employer. If your request for Bonding 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.
The leave period for which benefits are requested may only include dates within 12 months of the Childs birth date.

Bonding Claim Form 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 Family Leave ☐ Weeks _____ Days _____ (specific dates)
None ☐

Employment Status

Date of Employment: _____ Date Last Worked: _____
If no longer employed, date of termination: _____
State employee works in? _____

Financial Information

Employee base salary: $ _____
Salary prior to increase $ _____
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: _____

Please provide the gross earnings for the last 5 completed quarters prior to the leave start date.

Quarter Completed (ex: 1Q/2024)	Gross Earnings
	$
	$
	$
	$
	$

Bonding Claim Form
Employer Statement

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To be completed and signed by the employer - continued

Employer Reimbursement

If the Employee received full wages following the date last worked, will the Employer be requesting reimbursement? ☐ Yes ☐ No

If yes, please provide the following:

Amount paid: $ _____ Date benefits begin: _____ Date benefits end: _____

Please note by providing this information, you are indicating that you are entitled to receive reimbursement. The employee will not be paid by the PFML benefit. Instead, it will be reimbursed to you. To receive benefits directly, please complete the attached Employer reimbursement form.

State of Connecticut claims are not eligible for reimbursement.

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

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

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

Employer Reimbursement Policyholder Responsibilities

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If you have continued to pay the employee full compensation while on paid family and medical leave (PFML), and are requesting reimbursement, please review and complete this form.

Company's legal name (include Doing Business As), known as "Policyholder":

_____

Account number/s: _____

Policyholder as Principal's agent understands and acknowledges that it is the responsibility of Policyholder to withhold and remit accurate taxes from compensation paid to the employee representing the PFML benefit.

Policyholder as Principal's agent understands and acknowledges that it is the responsibility of Policyholder to report compensation representing PFML benefits on Form W-2 and/or Form 1099-MISC.

Policyholder agrees to indemnify, hold harmless, and release Principal from any liability and damages associated with the actions herein described perform by Policyholder as Principal's agent.

Principal agrees to reimburse the Policyholder for benefits paid in advance. Policyholder will only be reimbursed for days paid that Principal has deemed the employee is eligible for benefits and at the amount the Principal Life Insurance Company has calculated is due.

The PFML reimbursement will be issued via check separately by employee.

This agreement may be terminated by Principal Life Insurance Company anytime.

_____ _____
Signature of Policyholder's authorized representative Date

_____ _____
Printed name of signer Title

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www.principal.com

Bonding Claim Form
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. I acknowledge I have read the Notice Requirements on page 1 of this form.

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:

Will Paid Family Leave be for a continuous period of time or periodic?

☐ Continuous Start Date: _____ End Date: _____

☐ Periodic Identify dates periodic Paid Family 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.

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.

Signature: X	**Date:**

Bonding Certification

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Bonding Certification (to be completed by the employee)

1. **Child's date of birth** (MM/DD/YYYY) _____

2. **Child's gender** ☐ Male ☐ Female ☐ Nonbinary

3. **Does child live with the employee requesting Paid Family Leave?** ☐ Yes ☐ No

4. **Child is employee's:**
   ☐ Biological child ☐ Stepchild ☐ Foster child ☐ Adopted child ☐ Legal ward ☐ Spouse/Domestic partner's child ☐ Loco parentis

5. **Select one of the following and attach the document as required as evidence of the relationship.**

   Family Leave for Parent of a newborn Child:

   ☐ Child's birth certificate; OR

   ☐ Statement from the Childs Healthcare Provider stating the childs birth date; OR

   ☐ Statement from the Health Care Provider of the person who gave birth stating the Childs birth date

   Family Leave for the placement of Child for Adoption or Foster care:

   ☐ Statement confirming the placement and date of placement from; the Childs Healthcare Provider; OR an adoption or foster care agency involved in the placement; OR The Department of Children and Families

Consent to do Business Electronically with Principal Life Insurance Company

Administered by **Principal Life Insurance Company**
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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 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.