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

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
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Call: 800-245-1522 **Fax:** 800-255-6609
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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: ______

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

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

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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

Principal Life Insurance Company
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www.principal.com

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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.

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:**

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 11 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

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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.