



Administered by  
**Principal Life Insurance Company**  
 Attn: Group Life and Disability Claims Department  
 Des Moines, Iowa 50392-0002

**Disability Claim Form**

**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. To avoid delay in benefits, please answer all questions completely and legibly.
3. If you have any additional information you feel would help in the review of this claim, please attach to this form.
4. The authorization to release medical information (Page 5) must be completed for all claims and returned with the other sections.
5. Please include a photocopy of the insured/claimant's driver's license or other photo ID.

**Any person who, with intent to defraud or knowing that he or she is 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.**

**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 job title \_\_\_\_\_ Date in job \_\_\_\_\_

Employee hours worked per week \_\_\_\_\_ Date of employment \_\_\_\_\_

Effective date of employee's coverage \_\_\_\_\_ Date employee 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 \_\_\_\_\_ 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 # \_\_\_\_\_

Address of employee \_\_\_\_\_  
(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 and/or most recent **benefit** check stub.)

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

Please list current and/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) \_\_\_\_\_

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  unknown  
 If unknown, please explain: \_\_\_\_\_

**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 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

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

**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 \_\_\_\_\_ hrs/day      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, insurer, and/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 the 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, workers' 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 and/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 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 and/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: \_\_\_\_\_

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.