Accident Claim Form

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

Instructions to Employee

1. This form needs completed by you (employee), your employer and attending physician
2. Please answer all questions completely to help us process your claim quickly.
3. Please attach any additional information you believe will help in the review of the claim.
4. **A completed authorization for release of information (page 5) must be completed by the patient or patient representative of a minor/incapacitated adult.**
5. A Consent to do Business Electronically with Principal Life Insurance Company (page 6) can be completed if you'd like to communicate by email
6. This claim form may include injuries not covered under the policy. Please refer to your benefit booklet for a list of covered injuries

Statement of Employer

Employee's name		Date of birth	I.D. number	Job title
Group Number	Unit/Division number	Date of employment		Hours worked per week
Has the employee ceased working? ☐ yes ☐ no		Date Employee was last physically at work?		
Percentage of premium paid by employer	If less than 100%, premiums were paid with employee's ☐ pre-tax dollars ☐ post-tax dollars			
Employer name		Email address		
Signature of policyholder ▶		Title	Telephone number	Date

Statement of Employee (Please review the Notice Requirements prior to signing)

Employee's name	Date of birth	Social security number	Telephone number
Address		Email address	
Patient's name (if other than employee)	Patient's date of birth	Relationship to employee	

Accident Details: Attach itemized bills and supporting documents from the physician related to the injuries and services received, including date of service, diagnosis and procedure information. For accidental death benefit claims, attach the death certificate and any of the following which are available: incident report, autopsy/toxicology report, newspaper clippings, police department and contact name and phone number.

Date of accident	Time of accident ☐ a.m. ☐ p.m.	Location of accident	If accidental death, date of death

Describe the accident and resulting injuries (if car accident, attach the accident report)

Did the accident happen while working? ☐ yes ☐ no If yes, attach the employer incident report	Was a police report filed? ☐ yes ☐ no If yes, please attach

Name and phone numbers of all physicians treating the patient for the injury (attach separate list if more space is needed)	Dates consulted

These statements are true and complete to the best of my knowledge and belief.

Florida: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Maine: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

New York: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Signature of employee ▶	Date
Signature of patient (if other than employee) ▶	Date

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Attending Physician's Statement

Patient's name	Date of birth

Describe the accident and resulting injury:

Was the accident the direct and sole cause of this injury?	☐ yes ☐ no
Did this injury result from employment?	☐ yes ☐ no
Did any sickness, disease or prior injury contribute to this injury? If yes, explain:	☐ yes ☐ no
Are any of the following a contributing factor in this injury? Use of drugs, commission of a felony, intoxication, self-inflicted injury or suicide attempt? If yes, please specify which applies:	☐ yes ☐ no

Provide details for the injury(ies) the patient sustained as a result of the accident:	Date of Diagnosis	Date First Treated	ICD-9 code(s)	Type & date of surgery (attach operative report)
Burn				
☐ 2nd degree % of body covered _____% ☐ 3rd degree % of body covered _____% ☐ Skin graft Date: _____				
Coma				
Date coma began _____ Date coma ended _____ or current duration, if continuing _____ days Did the coma require intubation for respiratory assistance? ☐ yes ☐ no Was the coma medically-induced? ☐ yes ☐ no				
Concussion (attach medical imaging results)				
Dental injury – broken tooth requiring:				
☐ Extraction ☐ Crown ☐ Implant ☐ Denture Date treatment began: _____ Was the injured tooth a sound and natural tooth? ☐ yes ☐ no Was the injury caused by biting or chewing? ☐ yes ☐ no				
Dislocation (attach X-ray or major diagnostic exam reports)				
Joint(s) _____ ☐ Complete ☐ Partial ☐ Open reduction ☐ Closed reduction Did the dislocation require correction with anesthesia? ☐ yes ☐ no				
Eye injury (other than eyelid) **with surgical repair**				
Fracture (attach X-ray or major diagnostic exam reports)				
Bone(s) _____ ☐ Chip ☐ Open reduction ☐ Closed reduction				
Internal injury				
Was the injury related to a hernia? ☐ yes ☐ no If surgery, was it exploratory surgery without repair? ☐ yes ☐ no				
Torn, ruptured or severed knee cartilage with surgical repair				
Was surgery exploratory without repair? ☐ yes ☐ no				
Torn, ruptured or severed ligament with surgical repair				
Was surgery exploratory without repair? ☐ yes ☐ no				
Torn, ruptured or severed rotator cuff with surgical repair				
Was surgery exploratory without repair? ☐ yes ☐ no				
Ruptured disc with surgical repair				
Was surgery exploratory without repair? ☐ yes ☐ no				
Torn, ruptured or severed tendon with surgical repair				
Was surgery exploratory without repair? ☐ yes ☐ no				
Other injury: explain				

	Date of Diagnosis	Date First Treated	ICD-9 code(s)	
Accidental ingestion of controlled drugs (Connecticut only) (attach itemized bills showing billed charges not paid by any other source)				
If hospital confined, number of days _____				
Ambulance (Connecticut only) (attach itemized bills showing billed charges not paid by any other source)				
Name and phone number of ambulance company				

Accidental dismemberment

Date of dismemberment _____

☐ left hand ☐ right hand
☐ left foot ☐ right foot
☐ finger(s) ☐ toe(s) ☐ thumb and index finger on same hand

Is severance at or above wrist? ☐ yes ☐ no
Is severance at or above ankle? ☐ yes ☐ no
Is severance at or above metacarpophalangeal joints? ☐ yes ☐ no

Loss of use or paralysis

Date first treated patient _____ Date last treated patient _____

☐ left arm ☐ right arm
☐ left leg ☐ right leg
☐ left hand ☐ right hand
☐ left foot ☐ right foot

Is the loss caused by a stroke? ☐ yes ☐ no
Is the loss permanent, complete and irreversible? ☐ yes ☐ no
Has the loss continued for at least 12 consecutive months? ☐ yes ☐ no

Loss of sight

Date first treated patient _____ Date last treated patient _____

☐ left eye ☐ right eye

Can vision be corrected to better than 20/200? ☐ yes ☐ no
Is the loss permanent, complete and irreversible? ☐ yes ☐ no
Has the loss continued for at least 12 consecutive months? ☐ yes ☐ no

Loss of speech

Date first treated patient _____ Date last treated patient _____

Is the loss permanent, complete and irreversible? ☐ yes ☐ no
Has the loss continued for at least 12 consecutive months? ☐ yes ☐ no

Loss of hearing

Date first treated patient _____ Date last treated patient _____

☐ left ear ☐ right ear

Is the loss permanent, complete and irreversible? ☐ yes ☐ no
Has the loss continued for at least 12 consecutive months? ☐ yes ☐ no

Attending Physician's Signature

I hereby certify that the above information is based upon reasonable medical probability, and is true and correct to the best of my knowledge and belief.

Name of attending physician (please print)	Specialty	Telephone number	
Address	City	State	ZIP code
Signature ▶	Date	Medical ID#	

Notice Requirements

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.

Alabama: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

Arizona: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

Arkansas: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

California: For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

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.

District of Columbia: Warning: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Louisiana: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Maryland: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

New Hampshire: Any person who, with a purpose to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20

New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

New Mexico: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

Ohio: 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 is guilty of insurance fraud.

Oklahoma: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Pennsylvania: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Tennessee: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company. Penalties include imprisonment, fines and denial of coverage.

Virginia: Any person who, with the 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 have violated state law.

Washington: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

Authorization for Release of Personal Health and Other Information to Principal Life Insurance Company

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

I authorize any physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, health care provider, health plan and its administrator, disability plan and its administrator, insurer, 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, its agents, employees, insurance support organizations, reinsurers, and their representatives. This includes information on the diagnosis, treatment and/or testing results related to HIV, AIDs, sexually transmitted diseases, mental illness (excluding psychotherapy notes as defined under HIPAA) and the use of alcohol, drugs, and tobacco.

I authorize any health care provider who has personal information about my drug or alcohol use, including significant history, findings, diagnosis, or treatment, but excluding psychotherapy notes to give such data to Principal Life agents and employees performing my business transactions. I authorize Principal Life to release data as required by law. This data may include age, medical history, claims information, habits, and other personal characteristics and identifying information. This authorization will be valid two years from the date below. I may revoke authorization for information at any time, except to the extent Principal Life or any health care provider, which is to make the disclosure, has already acted in reliance on it. I understand data obtained will be used by Principal Life to administer this claim for accident benefits. Information will not be used for any purpose prohibited by law.

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 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, coordinate the provision of benefits under my accident coverage, and conduct other legally permissible activities that relate to any coverage I have or have applied for with Principal Life. I understand that any information disclosed under this authorization may no longer be covered by the privacy provisions of HIPAA and may be subject to redisclosure.

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 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 accident benefits. Upon my request, a copy of this completed authorization will be provided to me. Any alteration of this form will not be accepted.

Patient's or representative's signature ▶	Date	Incident #	
Patient's full name	Date of birth	Email address	
Address	City	State	ZIP code
Telephone number	Can confidential messages be left at this number? ☐ yes ☐ no		

OPTIONAL: I give you permission to speak with _____(full name) ☐ My spouse, ☐ Domestic Partner, or ☐ _____, concerning my claim.

If you are the representative of the patient (including a member acting as a representative on a dependent's behalf) describe the scope of your authority to act on the patient's behalf. Please include the proper documentation that attests to your ability to sign.

I certify that I am a citizen of the following country:

Country	Signature ▶	Date

Consent to do Business Electronically with Principal Life Insurance Company

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

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

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®

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