

Simplifying the Claim Process

Your Principal Absence Management Family Medical Leave Act (FMLA) and Short-Term Disability (STD) programs are administered by Principal Life Insurance Company. If you need to file for FMLA and/or STD, submitting the claim is probably one of the last things on your mind. The Principal Absence Management Center simplifies this process.

When to Report a Claim

If you need to miss work due to:

- your own serious health condition, which would include any illness, injury or maternity.
- care for your spouse, child or parent with a serious health condition.
- adoption or foster placement of a child.
- care for an injured service member.
- qualified exigence leave.

How to Report a Claim

Your claim specialists are as close as the nearest phone or computer. Follow these steps:

- Consult your benefit booklet or benefit department for the amount of time associated with your STD coverage before benefits may be payable (elimination period) and any deadlines for submitting claims.
- Sign, date and submit the Authorization form on the back of this document when your disability begins to authorize the release of information to our claims specialists. We cannot process your information without this form.

Email, fax or mail a copy of the completed authorization to:

Principal Life Insurance Company Attn: Life and Disability Claims Des Moines, IA 50392

Fax: 800-255-6609

Email: dlsbdclaims@exchange.principal.com

- Choose your preferred claim filing method:
 - Call Principal Absence Management Center to submit your claim at 877-734-3652 (877-PFG-FMLA) Monday through Friday from 7:30 AM to 9:30 PM Central Standard Time.
 - File online at: www.principal.absencemgmt.com

Information Needed to File a Claim

Be prepared with the following information when you make your claim request. If someone makes the call on your behalf, he or she will need to provide this information:

- Employer name:
- Policy number:
- Your name and Identification Number
- Address and phone number
- Date of birth
- Marital status
- Occupation (or job title)
- Reason for the claim: Your health condition of FMLA for a family member
- Location where you are employed

For your own serious health condition:

- Physician's name, address, fax and phone number.
- A brief description of your leave, which may include a summary of your condition including cause of condition (injury/illness), date of injury or beginning of illness, and whether or not it's work-related.
- The dates of your first visit, your most recent visit and your next scheduled visit with your physician for this condition.
- Your last day worked and your first day absent from work due to this condition.
- The date you expect to return to work (if known), or the actual date if you already returned to work at the time of your call.
- Work restrictions or limitations advised by your physician, (if applicable).

We suggest a call up to 30-days in advance of a planned medical absence, such as prescheduled surgery or an expected maternity leave, to ensure your STD and/or FMLA claim is ready when you need it.

The Authorization below gives your health care provider(s) the ability to release appropriate information about your condition to Principal Life for your Short-Term Disability claim. Sign and date the authorization when your disability begins. Show your health care provider(s) the document, and ask them to make a copy for your medical records. Be sure to email, fax or mail a completed copy of this authorization as requested on the reverse.

Authorization for Release Personal Health Information

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 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 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 medical and disability coverages, 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 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 signature: X		Date:	1	1
Claimant full name:		Date of birth:	1	1
Claimant address:				
Claimant city:	state:	zip:		
Personal email address:				
Telephone number: () Can confidential messages	be left at this number?	yes	no
	nember or the member's dependent (including a member acting the member's or dependent's behalf. Please include the proper docu			
I certify that I am a citizen of the follow	ing country:			
	X			
(Country)	(Signature)		(Date)