



Administered by  
**Principal Life Insurance Company**  
 Des Moines, Iowa 50392-0002  
 Toll Free # 1-800-245-1522  
 FAX # 1-800-255-6609

**Disability Claim Form**

**Instructions**

- (1) This form should be filed as soon as it appears your employee will be off work due to disability.
- (2) If you have any more information you feel would help us in the review of this claim, please attach.
- (3) To avoid delay in benefits, please fill out this form as completely as possible.
- (4) Describe job duties below or attach a copy of employee's job description.
- (5) If you need help completing this form, please call 1-800-245-1522.

**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**

Employee's name \_\_\_\_\_ I.D. number \_\_\_\_\_ Job title \_\_\_\_\_

Date of employment \_\_\_\_\_ Effective date of employee's coverage \_\_\_\_\_ Date employee last worked \_\_\_\_\_

Reason stopped working  illness  injury  other \_\_\_\_\_

% of premium paid by employer \_\_\_\_\_ % If not 100%, was premium paid with employee's pre-tax dollars?  yes  no  
 If you do not know if paid with pre-tax dollars, call 1-800-245-1522.

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 workers' compensation \_\_\_\_\_ Amount of workers' compensation received \$ \_\_\_\_\_

Name and address of workers' compensation carrier: \_\_\_\_\_

Type and amount of benefit claimed:  short term disability \$ \_\_\_\_\_  long term disability \$ \_\_\_\_\_  life coverage during disability \$ \_\_\_\_\_

Employee's salary: \$ \_\_\_\_\_  weekly  monthly  hourly  annually  
 Number of hours per week \_\_\_\_\_ Effective date of salary \_\_\_\_\_

If employee not paid by a standard wage, explain how they are paid. \_\_\_\_\_

Other sources of income:

pension \$ \_\_\_\_\_ /month  social security \$ \_\_\_\_\_ /month

state disability income \$ \_\_\_\_\_  other (define) \_\_\_\_\_ \$ \_\_\_\_\_ /month

Was salary continued after date last worked? . . . . .  yes  no If yes, when did it stop? \_\_\_\_\_

If yes, was amount paid the same as salary reported? . . . . .  yes  no If no, explain: \_\_\_\_\_

Describe specific job duties and physical demands or attach a copy of job description: \_\_\_\_\_

Employer \_\_\_\_\_ Plan number \_\_\_\_\_ Unit number \_\_\_\_\_

By (signature) \_\_\_\_\_ Title \_\_\_\_\_

Date \_\_\_\_\_ Telephone number (\_\_\_\_\_) \_\_\_\_\_ FAX number (\_\_\_\_\_) \_\_\_\_\_  
 Area code Area code

**Employee Statement**

Your name \_\_\_\_\_ Date of birth \_\_\_\_\_ Social security number \_\_\_\_\_

When did you become disabled? \_\_\_\_\_

Date returned to work  full-time \_\_\_\_\_  part-time \_\_\_\_\_ or  plan to return to work \_\_\_\_\_

Is disability due to  accident or  sickness? (Please describe accident, including date and place. OR When did sickness first start?)

Date first treated for this condition by a physician \_\_\_\_\_ Name of physician \_\_\_\_\_

Have you been hospitalized?  yes  no If yes, when? From \_\_\_\_\_ to \_\_\_\_\_

Name and address of hospital \_\_\_\_\_

Did disability result from employment?  yes  no Have you filed a workers' compensation claim?  yes  no

Other sources of income:

pension \$ \_\_\_\_\_ /month  social security \$ \_\_\_\_\_ /month  state disability income \$ \_\_\_\_\_

workers' compensation \$ \_\_\_\_\_  other \_\_\_\_\_ \$ \_\_\_\_\_

Please send copy of award letter and/or copy of most recent check stub. Also, do you receive these checks  weekly or  monthly?

Do you have disability insurance with other companies?  yes  no If yes, give names of companies and policy numbers: \_\_\_\_\_

Name, address and phone number of your doctors during the past year \_\_\_\_\_ Sickness or injury \_\_\_\_\_ Date seen \_\_\_\_\_

These statements are true and complete to the best of my knowledge. \_\_\_\_\_ (Signature of employee) \_\_\_\_\_ (Date)

**Authorization for Release of Information**

I authorize my medical/mental health professional, counselor, clinic, insurance company or benefits administrator, hospital, other medical facility or employer to give any information or record it has about me, my physical or mental health to Principal Life Insurance Company (The Principal®) or its authorized representative. This shall include but not be limited to:

- Consultation reports
- Hospital records
- Treatment records/office notes
- Alcohol or drug abuse treatment
- Employment information
- Workers' compensation information
- Diagnosis
- Prescriptions
- Test results
- Vocational testing/counseling information
- License or certification status
- Benefit information

I understand this information will be used to determine my eligibility for benefits under any insurance plan and may be reviewed by claims, underwriting or legal personnel, or by other personnel of The Principal. I authorize The Principal to release any such information related to any insurance plan under which I am insured or related to any insurance claim I have made to:

- Persons or organizations inside or outside of The Principal performing business, legal or medical services.
- Employer or former employer as needed to perform fiduciary responsibility under any benefit plan.

This authorization shall be valid as long as I have a claim for benefits with The Principal or until revoked by me in writing. I have read and I understand this authorization. I know that I may request and receive a copy of it. A photocopy of this authorization shall be considered as effective and valid as the original.

\_\_\_\_\_  
(Signature) (Date)

Address of employee \_\_\_\_\_  
(Street) (City) (State) (ZIP code)

Telephone number (\_\_\_\_\_) \_\_\_\_\_  
Area code

**DISABILITY CLAIM FORM**

Patient's name: \_\_\_\_\_ Social security number: \_\_\_\_\_ Date of birth: \_\_\_\_\_

**Attending Physician's Statement (page A)**

The purpose of this statement is to assist the claim examiner in making a determination of disability for your patient. Thank you for completing page A and page B of this statement.

**HISTORY**

What date did symptoms first appear or accident happen? . . . . . \_\_\_\_\_

Has patient ever had same or similar condition? . . . . .  yes  no

If yes, state when and describe:

Is condition due to injury or sickness arising out of patient's employment? . . . . .  yes  no  unknown

Names and addresses of other treating physicians: \_\_\_\_\_

**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? . . . . . \_\_\_\_\_

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

**DATES OF TREATMENT**

Date of first visit \_\_\_\_\_ Date of last visit \_\_\_\_\_

Frequency of visits  weekly  monthly  other (specify) \_\_\_\_\_

Has patient been hospitalized?  yes  no If yes, name and address of hospital:

Dates confined \_\_\_\_\_

**NATURE OF TREATMENT (Including any surgery or medications prescribed.)**

CPT-4 code: \_\_\_\_\_

**CARDIAC (if applicable)**

Functional capacity (American Heart Association)  Class 1 (No limitation)  Class 2 (Slight limitation)  
 Class 3 (Marked limitation)  Class 4 (Complete limitation)

**DISABILITY CLAIM FORM**

Patient's name: \_\_\_\_\_ Social security number: \_\_\_\_\_ Date of birth: \_\_\_\_\_

**Attending Physician's Statement (page B)**

**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**

Have you told the patient to restrict employment activities?  yes  no

Date restrictions began \_\_\_\_\_ Date restrictions end \_\_\_\_\_

Explain the specific restrictions and limitations:

Do you expect a fundamental or marked change in the future?  yes  no

If yes, when will patient recover sufficiently to return to work?  1 month  1-3 months  4-6 months  on \_\_\_\_\_

If no, please explain:

**RETURN TO WORK/CASE MANAGEMENT**

Can present job be modified to allow the patient to work with impairment?  yes  no If yes, please explain.

Date trial employment could begin? **PATIENT'S JOB**  full-time  part-time \_\_\_\_\_

**ANY OTHER JOB**  full-time  part-time \_\_\_\_\_

Would vocational counseling and/or retraining be recommended?  yes  no

**PRINT physician's name** \_\_\_\_\_ **Degree** \_\_\_\_\_ **Specialty** \_\_\_\_\_ **Telephone** \_\_\_\_\_

**Street address** \_\_\_\_\_ **City** \_\_\_\_\_ **State or province** \_\_\_\_\_ **ZIP code** \_\_\_\_\_ **Tax identification number** \_\_\_\_\_

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_ **FAX number** \_\_\_\_\_