

Paid Family and Medical Leave Serious Health Condition Claim Instructions

Administered by
Principal Life Insurance Company
Attn: Group Life and Disability Claims
PO BOX 14472
Des Moines, Iowa 50306-3472
Ph 800-245-1522 Fax 800-255-6609
Email: SBDClaims@principal.com



Don't Forget! You can submit claims directly on the web at www.principal.com/FileAClaim

Application Process

The included forms are required to apply for your leave benefits. They must be completed in their entirety by you, your employer and your treating provider. Below are the steps required to submit your claim. 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.

Questions? Contact 800-245-1522 from 7:30 am to 5:00 pm CT.

- ☐ Complete and Sign the Employee Statement (page 2)
Read the Notice Requirements for your state above the signature section.
- ☐ Request Employer Statement (pages 3-5)
To process your claim, your employer needs to fill out a statement. Provide them a copy of the form in this packet or they can go to www.principal.com/FileAClaim.
- ☐ Request Health Care Provider statement (pages 6-7)
We'll need statements from all providers you're seeing related to this claim. A single statement form is included in this packet, but additional copies are available through your employer's benefit administrator or online at www.principal.com/FileAClaim.
- ☐ OPTIONAL: Sign and date the Consent to do Business Electronically (page 8)
This form allows us to communicate with you through email which can reduce delays in claim processing. Permission can be revoked at any time.
- ☐ OPTIONAL: Complete, sign and date the Authorization Agreement for Electronic Funds Transfer (page 9)
This form allows us to deposit any benefits directly into your bank account. Choosing direct deposit can cut down on the amount of time it takes to get your payment if your claim is approved.

Next Steps after Submission

Once we receive your claim request, we start working! You'll shortly receive an acknowledgement letter, either through the mail or digitally, acknowledging that we've received your claim.

A claims specialist will reach out to you to gather more information, clarify any questions about your submission, and go over the expected timeline of your claim. We may also reach out to your employer or provider(s) to gather more information if necessary. If your request for Leave is approved, the payments are typically paid weekly.

Paid Family and Medical Leave
Serious Health Condition
Employee Statement

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Basic Information

*Required Field

Employee Name*					Email		
Social Security #*		Date of Birth*		Gender*	☐ Male ☐ Female ☐ Nonbinary	Pref. Language	
Street Address*	Street						
	City				State	ZIP	
Mailing Address if Different							
Phone Number*				Mobile Carrier if Cell # Provided			

☐ By checking this box I give permission for Principal to text me regarding my claim, understanding that standard text message and/or data rates may apply.

Claim Information

Reason for Leave* (Check one)	☐ Your Own Serious Health Condition		
	☐ Care for a Family Member	Relationship to Employee	
Medical or Paid Family Leave (PFL) type*:	☐ Continuous	Date Started	Date Ended
	☐ Periodic	Dates of Periodic Leave	
Other benefits you have applied for OR are currently receiving? (Check all that apply)	☐ Social Security (Disability)	☐ Unemployment	☐ Workers' Compensation
	☐ Other _____	Date began	Amount: _____

Notice Requirements

General Notice: 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.

By signing this form, I declare that all the statements listed are true and completed to the best of my knowledge.

Signature*		Date*	
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Serious Health Condition
Employer Statement

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Company Information

*Required Field

Group Policy Holder Name*					
Legal Company Name	☐ Same as Above ☐ Other:				
Account #*		Bill Group #*		Member Class*	

Employee Information

Employee Name*				Member ID*	
Job Title*				Phone Number*	
Social Security #*				Date of Birth*	
Street Address*	Street				
	City			State	ZIP

☐ By checking this box, I'm noting this employee works in the state of _____, a different state than listed above

Claim Information

Leave for?*	☐ Employee Recovery ☐ Family Member Care						
Regular Schedule* (hours/day)	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Worker's Compensation*	☐ Filed, decision pending ☐ Awarded ☐ Denied ☐ N/A						

Note: Please provide a copy of all Worker's Compensation filings, including award/denial letters, with this statement

Employment Information and Finances

Date of Hire*		Termination Date	
Date Last Worked* Anticipated date if in the future		Date Returning to work Anticipated date if in the future	☐ Full Time ☐ Part Time

In the preceding 52 weeks this employee has taken leave for...

If necessary, multiple date ranges can be listed separated by a comma.

Disability	# of Weeks:		Exact Dates:
PFML	# of Weeks:		Exact Dates:

☐ This employee has NOT taken any disability or PFML in the preceding 52 weeks

Paid Family and Medical Leave
Serious Health Condition
Employer Statement - continued

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Gross Quarterly Earnings*

Please provide gross earnings information for the five (5) most recent completed quarters prior to the leave start date, starting with the most recent. (Ex. 1Q/2025)

Quarter:		Earnings:	\$
Quarter:		Earnings:	\$
Quarter:		Earnings:	\$
Quarter:		Earnings:	\$
Quarter:		Earnings:	\$

Pay After Last Day Worked* (fill in all that apply)

Did employee receive full pay after last day worked?*		☐ Yes		☐ No, _____%		☐ None	
Salary Continuance	Date Started	Date Ended	PTO	Date Started	Date Ended		
Sick Pay	Date Started	Date Ended	Vacation	Date Started	Date Ended		

Employer Reimbursement

If the employee received full wages following the date last worked, will the employer be requesting reimbursement?		☐ Yes		☐ No	
If yes, Amount paid:	\$	Date benefits began:		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 below Employer reimbursement form. *State of Connecticut claims are not eligible for reimbursement.

By signing this form I declare that all the statements listed are true and completed to the best of my knowledge.

Signature*				Date*	
Name*				Title*	
Phone Number*		Email			

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Employer Statement - continued

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Employer Reimbursement Policyholder Responsibilities

Policyholder as an agent of Principal® 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 an agent of Principal 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 an agent of Principal.

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 has calculated is due.

The PFML reimbursement will be issued via check separately by employee.

This agreement may be terminated by Principal anytime.

Signature		Date	
Name		Title	

Paid Family and Medical Leave
Serious Health Condition
Health Care Provider
Medical Certification

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Employee Information

*Required Field

Employee Name*				Date of Birth*		
Type of Leave* (Check one)	☐ Continuous	☐ Intermittent	Start date*		End date*	
Is it medically necessary for them to miss work due to their own serious health condition?*	☐ Yes ☐ No		Return to Work Date:			
If yes, please identify the job duties the employee is unable to perform.						

Patient Information

Patient's Name (if other than employee)				Patient's Date of Birth	
Relationship to employee				Patient Requires Care by this Employee	☐ Yes ☐ No
Estimated frequency they require leave*	_____ times per		☐ Day ☐ Week ☐ Month		
Estimated duration per episode*			☐ Hours ☐ Days		
Is patient competent to endorse and direct the use of those proceeds?*	☐ Yes ☐ No				

Medical Information

Diagnosis Codes* (ICD-10)			
Date of Onset*		Expected date patient no longer requires care*	

Patient's Serious Health Condition* (check all that apply)			
☐	Inpatient care (i.e., an overnight stay) in a hospital, hospice, or residential medical care facility.		
	Facility Name:	Admission Date:	Discharge Date:
☐	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	

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Health Care Provider
Medical Certification - continued

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Visits and Frequency

First Visit*		Most Recent		Next Scheduled	
Frequency?	☐ Daily ☐ Weekly ☐ Monthly ☐ Quarterly ☐ Other:				

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

Signature* (No Stamp)				Date*		
Physician Name*					Deg.*	
Specialty*			Phone Number*			ext.
Email				Fax Number		
Practice Address	Street					
	City			State	ZIP	

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 contact 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: _____

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 phone 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.

Name(s) on account _____

☐

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.

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
Phone 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.