

Paid Family Leave for bonding with a newly born, adopted or fostered child 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 bonding benefits. They must be completed in their entirety by you and your employer. 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. The dates of your leave must be within 12 months of the child's date of birth.

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.
- ☐ Complete the Bonding Certification (page 3)
Attach required documents as required as evidence of the relationship
- ☐ Request Employer Statement (pages 4-5)
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.
- ☐ OPTIONAL: Sign and date the Consent to do Business Electronically (page 6)
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 7)
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 Leave
Bonding Claim Form
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

Group Policyholder Name*			
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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Paid Family Leave
Bonding Certification

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Bonding Certification (to be completed by the employee)

Child's date of birth:*		Does child live with the employee requesting Paid Family Leave?*	☐ Yes ☐ No
Child is employees:*			
☐ Biological child ☐ Stepchild ☐ Foster child ☐ Adopted child ☐ Legal ward ☐ Spouse/Domestic partner's child ☐ Loco parentis			
Select one of the following and attach the document as required as evidence of the relationship.			
Family Leave for Parent of a newborn Child:			
☐ Child's birth certificate; OR			
☐ Statement from the Child's Healthcare Provider stating the child's date of birth; OR			
☐ Statement from the Health Care Provider of the person who gave birth stating the Child's birth date			
Family Leave for the placement of Child for Adoption or Foster care:			
☐ Statement confirming the placement and date of placement from; the Child's Healthcare Provider; OR an adoption or foster care agency involved in the placement; OR The Department of Children and Families			

Paid Family Leave
Bonding Claim Form
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

Employment Information and Finances

Date of Hire*			Termination Date				
Date Last Worked*			Date Returning to work			☐ Full Time ☐ Part Time	
Anticipated date if in the future		Anticipated date if in the future					
Regular Schedule* (hours/day)	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Current Base Pay and Frequency of this Pay*	\$_____ ☐ Hourly ☐ Weekly ☐ Bi-weekly ☐ Bi-Monthly ☐ Monthly ☐ Yearly						
Current Pay Effective Date*							

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

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

Paid Family Leave
Bonding Claim Form
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:	\$

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	

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.					

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	

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: _____

GP62604-00

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.