Critical Illness 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 should be completed in its entirety by the employer, the employee and attending physician.
2. To avoid delay in benefits, please answer all questions completely and legibly.
3. If you have any additional information you feel would help in the review of this claim, please attach to this form.
4. **A completed authorization for release of information (last page) must accompany this form.**
5. This claim form may include Critical Illnesses not covered under the policy. Please refer to your benefit booklet for a list of covered Critical Illnesses.

Statement of Employer

Employee's name	Date of birth	I.D. number	Group number

Unit/Division number	Date of employment	Effective date of plan	Hours worked per week

Percentage of premium paid by employer	If less than 100%, were premiums paid with employee's ☐ pre-tax dollars ☐ post-tax dollars

Has the employee ceased working? ☐ yes ☐ no If yes, reason:	Date employee last worked?	Is employee's coverage still in force? ☐ yes ☐ no If no, give date of termination

Employer name	Email address

Signature of policyholder ▶	Title	Telephone number	Date

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

Employee name _____ Address _____

Telephone number _____ Date of birth _____ Social security number _____

Main contact/Personal Email address _____

Patient's name (if other than employee) _____ Relationship to employee _____

Patient's date of birth _____ Full-time student? ☐ yes ☐ no

What is the specific critical illness for which the claim is being made? _____ When was it first diagnosed? _____

Name and phone numbers of all physicians treating the patient for the critical illness (attach a separate list if space needed)	Dates Consulted

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.

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

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	Date of death (if applicable)

When did signs and/or symptoms first appear?

Has the patient ever received medical advice or treatment for this or a similar condition prior to this occurrence? ☐ yes ☐ no if "yes", when

Is patient competent to endorse and direct the use of those proceeds? ☐ yes ☐ no

Diagnosis (including complications)

Date of diagnosis	ICD-9 Code(s)
Type of surgery	Date of surgery

Current medications

Are any of the following a contributing factor in the condition? Use of drugs, commission of a felony, intoxication, self-inflicted injury or suicide attempt, or cosmetic/elective surgery?	☐ yes ☐ no
If yes, please specify which applies:	
To your knowledge, has the patient used tobacco products in the past 12 months?	☐ yes ☐ no

Cancer

If the cancer/carcinoma in situ was clinically diagnosed, please provide the reason(s) that pathological diagnosis was not obtained, attach medical evidence that supports the diagnosis, and details of treatment.

Is there a prior diagnosis of this cancer? If so:	☐ yes ☐ no
1. What date was treatment completed?	
2. What date did the patient achieve full remission (no evidence of disease)?	

Heart Attack

Did the patient have typical clinical symptoms consistent with myocardial infarction, such as central chest pain?	☐ yes ☐ no
Are new and serial electrocardiographic (EKG) findings consistent with myocardial infarction? Attach a copy of the EKG tracings and interpretations.	☐ yes ☐ no
Was there a diagnostic increase of cardiac enzymes for myocardial infraction? Attach copies of lab reports documenting troponin and CPK-MB levels.	☐ yes ☐ no

Coronary Artery Bypass Graft (CABG)

Did the patient require median sternotomy to correct narrowing or blockage of one or more coronary arteries with bypass grafts? If so, attach a copy of the operative report.	☐ yes ☐ no
What was the indication for coronary artery bypass grafting?	

Major Organ Failure

Did the patient experience irreversible end stage failure of heart, lung, kidney, liver, bone marrow or pancreas? Please list date that any of the following occurred for the organ failure listed above: ➢ For kidney failure only, date dialysis was initiated _____ ➢ The date that the patient was listed with UNOS _____ ➢ The date that a suitable donor was found without a UNOS listing _____ Provide documentation of the major organ failure and either an item checked above or an operative report if the transplant was performed.	☐ yes ☐ no

Stroke

Did the patient have death of brain tissue due to an acute cerebrovascular event, not related to cerebral injury from trauma or hypoxia, and is there evidence on a CT, MRI or similar imaging technique that a stroke has occurred?	☐ yes ☐ no
Is there a new neurological deficit which has persisted 30 days after the event?	☐ yes ☐ no
Please submit medical records and complete an assessment of the patient's status using the Modified Rankin scale.	

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 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.

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 a false or fraudulent 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 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 he or she is 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 he or she is 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 or my dependents 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 and treatment of mental illness (excluding psychotherapy notes as defined under HIPAA).

I authorize any health care provider who has personal information about drug or alcohol use, including significant history, findings, diagnosis, or treatment, but excluding psychotherapy notes, regarding me or any dependent, 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 critical illness benefits. Information will not be used for any purpose prohibited by law.

I understand my or my dependents 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 critical illness coverage, 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 or my dependents, 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 my dependents and 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 or my dependent's complete medical record, Principal Life may not be able to process my application for critical illness benefits. Upon my request, a copy of this completed authorization will be provided to me. Any alteration of this form will not be accepted.

Claimant's signature: _____ **Date:** _____ **Incident #** _____

Claimant's full name: _____ **Date of birth:** _____

Claimant's address: _____

Main contact/Personal Email address: _____

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 during my disability.

If you are the representative of the member or the member's dependent (including a member acting as a representative on a dependent's behalf) describe the scope of your authority to act on the member's or dependent'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)

Print

