# Accident 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, employee and attending physician.
2. If additional information would help in the review of this claim, please attach to this form.
3. This form may include injuries not covered by your policy. Please refer to your benefit booklet for a list of covered injuries.
4. **A completed authorization signed by the patient for release of information (last page) must accompany this form.**

## Statement of Employer

| Employee's name | Date of birth | I.D. number | Job title |
|---|---|---|---|
| | | | |

| Date of employment | Employee's coverage effective date | Hours worked per week |
|---|---|---|
| | | |

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

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

| Employer name | Email address | Group number | Unit/division number |
|---|---|---|---|
| | | | |

| Signature of policyholder ▶ | Title | Telephone number | Date |
|---|---|---|---|
| | | | |

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

| Employee's name | Date of birth | Social security number | Telephone number |
|---|---|---|---|
| | | | |

| Address | Email address |
|---|---|
| | |

| Patient's name (if other than employee) | Patient's date of birth | Relationship to employee | Full-time student?<br>☐ yes ☐ no |
|---|---|---|---|
| | | | |

**Accident Details**: Attach itemized bills and supporting documents from the physician related to the injuries and services received, including date of service, diagnosis and procedure information. For accidental death benefit claims, attach the death certificate and any of the following which are available: incident report, autopsy/toxicology report, newspaper clippings, police department and contact name and phone number.

| Date of accident | Time of accident<br>☐ a.m. ☐ p.m. | Location of accident | If accidental death, date of death |
|---|---|---|---|
| | | | |

Describe the accident and resulting injuries (if car accident, attach the accident report)

| Did the accident happen while working? ☐ yes ☐ no<br>If yes, attach the employer incident report | Was a police report filed? ☐ yes ☐ no<br>If yes, please attach |
|---|---|
| | |

| Name and phone numbers of all physicians treating the patient for the injury (attach separate list if more space is needed) | Dates consulted |
|---|---|
| | |
| | |

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

**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.**

**New York:** 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

| Signature of employee ▶ | Date |
|---|---|
| | |

| Signature of patient (if other than employee) ▶ | Date |
|---|---|
| | |

 

Accident Claim Form

Administered by
**Principal Life Insurance Company**
**Attn: Group Life and Disability Claims Department**
Des Moines, Iowa 50392-0002

Principal®

## Attending Physician's Statement

| Patient's name | Date of birth |
|---|---|
| | |

Describe the accident and resulting injury:

| | |
|---|---|
| Was the accident the direct and sole cause of this injury? | ☐ yes ☐ no |
| Did this injury result from employment? | ☐ yes ☐ no |
| Did any sickness, disease or prior injury contribute to this injury? If yes, explain: | ☐ yes ☐ no |
| Are any of the following a contributing factor in this injury? Use of drugs, commission of a felony, intoxication, self-inflicted injury or suicide attempt? If yes, please specify which applies: | ☐ yes ☐ no |

| Provide details for the injury(ies) the patient sustained as a result of the accident: | Date of Diagnosis | Date First Treated | ICD-9 code(s) | Type & date of surgery (attach operative report) |
|---|---|---|---|---|
| **Burn** | | | | |
| ☐ 2nd degree % of body covered _____%<br>☐ 3rd degree % of body covered _____%<br>☐ Skin graft Date: _____ | | | | |
| **Coma** | | | | |
| Date coma began _____<br>Date coma ended _____ or current duration, if continuing _____ days<br>Did the coma require intubation for respiratory assistance? ☐ yes ☐ no<br>Was the coma medically-induced? ☐ yes ☐ no | | | | |
| **Concussion** (attach medical imaging results) | | | | |
| **Dental injury** – broken tooth requiring: | | | | |
| ☐ Extraction ☐ Crown<br>☐ Implant ☐ Denture<br>Date treatment began: _____<br>Was the injured tooth a sound and natural tooth? ☐ yes ☐ no<br>Was the injury caused by biting or chewing? ☐ yes ☐ no | | | | |
| **Dislocation** (attach X-ray or major diagnostic exam reports) | | | | |
| Joint(s) _____<br>☐ Complete ☐ Partial<br>☐ Open reduction ☐ Closed reduction<br>Did the dislocation require correction with anesthesia? ☐ yes ☐ no | | | | |
| **Eye injury** (other than eyelid) **with surgical repair** | | | | |
| **Fracture** (attach X-ray or major diagnostic exam reports) | | | | |
| Bone(s) _____ ☐ Chip<br>☐ Open reduction ☐ Closed reduction | | | | |
| **Internal injury** | | | | |
| Was the injury related to a hernia? ☐ yes ☐ no<br>If surgery, was it exploratory surgery without repair? ☐ yes ☐ no | | | | |
| **Torn, ruptured or severed knee cartilage with surgical repair** | | | | |
| Was surgery exploratory without repair? ☐ yes ☐ no | | | | |
| **Torn, ruptured or severed ligament with surgical repair** | | | | |
| Was surgery exploratory without repair? ☐ yes ☐ no | | | | |
| **Torn, ruptured or severed rotator cuff with surgical repair** | | | | |
| Was surgery exploratory without repair? ☐ yes ☐ no | | | | |
| **Ruptured disc with surgical repair** | | | | |
| Was surgery exploratory without repair? ☐ yes ☐ no | | | | |
| **Torn, ruptured or severed tendon with surgical repair** | | | | |
| Was surgery exploratory without repair? ☐ yes ☐ no | | | | |
| **Other injury: explain** | | | | |

 

| | Date of Diagnosis | Date First Treated | ICD-9 code(s) | |
|---|---|---|---|---|
| **Accidental ingestion of controlled drugs (Connecticut only)** (attach itemized bills showing billed charges not paid by any other source) | | | | |
| If hospital confined, number of days _____ | | | | |
| **Ambulance (Connecticut only)** (attach itemized bills showing billed charges not paid by any other source) | | | | |
| Name and phone number of ambulance company | | | | |

**Accidental dismemberment**

Date of dismemberment _____

☐ left hand ☐ right hand
☐ left foot ☐ right foot
☐ finger(s) ☐ toe(s) ☐ thumb and index finger on same hand

Is severance at or above wrist? ☐ yes ☐ no
Is severance at or above ankle? ☐ yes ☐ no
Is severance at or above metacarpophalangeal joints? ☐ yes ☐ no

**Loss of use or paralysis**

Date first treated patient _____ Date last treated patient _____

☐ left arm ☐ right arm
☐ left leg ☐ right leg
☐ left hand ☐ right hand
☐ left foot ☐ right foot

Is the loss caused by a stroke? ☐ yes ☐ no
Is the loss permanent, complete and irreversible? ☐ yes ☐ no
Has the loss continued for at least 12 consecutive months? ☐ yes ☐ no

**Loss of sight**

Date first treated patient _____ Date last treated patient _____

☐ left eye ☐ right eye

Can vision be corrected to better than 20/200? ☐ yes ☐ no
Is the loss permanent, complete and irreversible? ☐ yes ☐ no
Has the loss continued for at least 12 consecutive months? ☐ yes ☐ no

**Loss of speech**

Date first treated patient _____ Date last treated patient _____

Is the loss permanent, complete and irreversible? ☐ yes ☐ no
Has the loss continued for at least 12 consecutive months? ☐ yes ☐ no

**Loss of hearing**

Date first treated patient _____ Date last treated patient _____

☐ left ear ☐ right ear

Is the loss permanent, complete and irreversible? ☐ yes ☐ no
Has the loss continued for at least 12 consecutive months? ☐ yes ☐ no

## 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 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 my drug or alcohol use, including significant history, findings, diagnosis, or treatment, but excluding psychotherapy notes 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 accident benefits. Information will not be used for any purpose prohibited by law.

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 accident 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, 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 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 accident benefits. Upon my request, a copy of this completed authorization will be provided to me. Any alteration of this form will not be accepted.

| Patient's or representative's signature ▶ | Date | Incident # | |
|---|---|---|---|
| Patient's full name | Date of birth | Email address | |
| Address | City | State | ZIP code |
| 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.

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