

**Instructions to Beneficiary**

(Use this form for both member and dependent claims.)

If you have any questions completing this claim form, call Principal Life Insurance Company at 1-800-245-1522.

**(1) Complete Part II and Part III of the form.**

The following information may help you.

**More than one beneficiary** – If more than one beneficiary is named, each beneficiary needs to complete a claim form.**Member's estate as beneficiary; minor/incompetent beneficiary; predeceased beneficiary** - If the life benefit is determined to be due and payable to any of these beneficiaries, there may be additional information required in order to release the benefit. A company representative will contact you to request information when appropriate.**Additional information** - Principal Life reserves the right to require and obtain such statements, authorizations and other information as it deems necessary to determine what benefits are payable on any claim.**(2) Complete Part IV on the form.**

Carefully review the payment methods available to you and elect the method most appropriate for your situation in Part III of the form.

**NOTE** - You will not qualify for the Interest Draft Account Option if you are a minor, a company, corporation, estate or trust, or if the proceeds payable to you are less than \$5,000.**(3) If accidental death/personal loss benefits are being claimed, the following information may be needed. Please provide any of these documents you may already have:**

- Incident Report
- Autopsy/toxicology reports
- Newspaper clippings
- Investigating police department and contact name and phone number
- If member's death occurs more than 100 miles from permanent place of residence and costs are incurred for preparation and transportation of the body, please enclose a copy of the associated expenses.
- The policy may provide additional accidental death/personal loss benefits if the member has "Qualified Students." A "Qualified Student" is a dependent child who is, at the time of death, a full-time student at an accredited post-secondary school or a 12th grade student if he/she enrolls in an accredited post-secondary school within 12 months of death. If there is a "Qualified Student," please call the 800 number listed above to determine if additional benefits are applicable and to obtain the necessary form to apply for this benefit. (This benefit not approved in some states.)
- Complete attached authorization page and return with the other documents requested.

**(4) Attach a certified copy of the deceased member's (dependent's) death certificate. If the death occurred outside the United States, attach a copy of document entitled "Death of an American Citizen" from the U.S. Embassy.****(5) Return the completed form and death certificate to the group planholder.****Instructions to Group Planholder****(1) Complete Part I of this form accurately and completely to avoid any delays in payment of the benefits.****NOTE** - If more than one beneficiary is named, you must provide a form to each beneficiary for completion of Part II and Part III of the form. You need not complete Part I on all the forms. If possible, please submit all claim forms at the same time.**(2) Return the completed form(s) and any other information you may have, such as:**

- (a) enrollment forms, (b) change of beneficiary forms, (c) assignments, (d) settlement instructions to:

Principal Life Insurance Company  
Attn: Group Claim - Life and Disability  
Des Moines, Iowa 50392-0002



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

**Life Claim Information**

**Part I: Information about the Group Planholder**

Member's name (Please list all names member may have been known by such as maiden name, nickname or alias) \_\_\_\_\_ Member's I.D. \_\_\_\_\_

If dependent death, name \_\_\_\_\_ Relationship to member \_\_\_\_\_

Member's job title \_\_\_\_\_ Member's classification in policy \_\_\_\_\_ Salary \_\_\_\_\_ Effective date of salary \_\_\_\_\_  
 \$

Effective date of member's coverage \_\_\_\_\_ Date member began employment \_\_\_\_\_ Number of hours worked per week \_\_\_\_\_ Date member was last actively at work \_\_\_\_\_

Reason member ceased active work:

death  retired  illness or injury  terminated  other (explain) \_\_\_\_\_

Were premiums paid through date of death?  yes  no

If dependent claim, was member working at the time of death?  yes  no

If no, what was the date last worked? \_\_\_\_\_ If dependent, is member still working?  yes  no

Did the member name more than one beneficiary?  yes  no If yes, are all claim forms attached?  yes  no

Amount of benefit claimed \$ \_\_\_\_\_

Employer name \_\_\_\_\_ Policy number \_\_\_\_\_ Unit/division number \_\_\_\_\_

Signature of planholder \_\_\_\_\_ Title \_\_\_\_\_ Date \_\_\_\_\_

If we have questions, your phone number is \_\_\_\_\_ FAX number \_\_\_\_\_

**Part II: Information about the Deceased**

Deceased's name \_\_\_\_\_

Address - street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Date of birth \_\_\_\_\_ Date of death \_\_\_\_\_ Social security number \_\_\_\_\_

Are you making claim to any accidental death/personal loss benefit provided by the policy?  yes  no  
 If yes, please send us any newspaper articles, accident reports, or other documentation that would provide us with information about the death.

Was member (dependent) insured under any other policies with other companies?  yes  no  
 If yes, give name of company and amount of insurance: \_\_\_\_\_

Did member (dependent) have other coverage with Principal Life?  GUL  Individual  Group  Pension

**Part III: Information about the Beneficiary**

Your name (beneficiary) \_\_\_\_\_ Date of birth \_\_\_\_\_

Your address - street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Your phone number - home \_\_\_\_\_ Your phone number - work \_\_\_\_\_

You are making claim to:  all of the proceeds on the deceased's claim.  
 only the portion due me as one of the beneficiaries of the member.

Your relationship to member:  spouse  child  other (explain) \_\_\_\_\_

GROUP PLANHOLDER: please return to Principal Life Insurance Company

**IV. Settlement Information**

I wish my benefits to be paid by:

- Interest Draft Account** - This account is like a checking account which earns interest. You can write personal drafts in the amount of \$500 or more. Your money earns interest until your draft clears and is fully guaranteed by Principal Life. You name a beneficiary to any benefits remaining in the account in the event of your death. You also have the right to transfer funds to other options or purchase other products available from Principal Financial Group. You will receive shortly a packet of information regarding the Interest Draft Account. Included in this packet will be a Beneficiary Designation Form.
- Please send me additional information about other options available to me from Principal Financial Group.**
- Lump Sum Payment**

**Request for Taxpayer's Social Security Number or Tax Identification and Certification.**

If the social security number or tax identification number of the beneficiary is not supplied, the beneficiary may be subject to federal and state tax withholding. I have provided the appropriate social security or tax identification number below:

- The benefits are being claimed by me as a beneficiary and my social security number is \_\_\_\_\_
- The benefits are being claimed by the legal guardian of a minor/incompetent person's estate.  
The minor/incompetent person's social security number is \_\_\_\_\_
- The benefits are being claimed by a trustee of a trust or a personal representative of an estate.  
The tax identification number for the trust or estate is \_\_\_\_\_

The information provided by me on this claim form is true and complete to the best of my knowledge. Under penalty of perjury I certify that the social security number or tax identification number supplied on this form is true, correct, and complete.

Date \_\_\_\_\_ Signature of beneficiary (Please make sure your sign form as your name appears on your social security card.) \_\_\_\_\_



**Certification of Foreign Status (For Foreign Entities Only)**

Under penalties of perjury, I certify that for interest payments, I am not a U.S. citizen or resident (or I am filing for a foreign corporation, partnership, estate, or trust).

U.S. taxpayer's identification number (if any) \_\_\_\_\_ Country of citizenship \_\_\_\_\_  
 SSN  ITIN  EIN  
Permanent address \_\_\_\_\_

Date \_\_\_\_\_ Signature \_\_\_\_\_



## Notice Requirements

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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.

**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.

**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.

**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.

**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.

**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.



Mailing Address:  
Des Moines, IA 50392-0002

Principal Life  
Insurance Company

**Group Life Authorization for Release  
of Personal Health and  
Other Information to  
Principal Life Insurance Company**

I authorize any physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, emergency care provider, health care provider, health plan and its administrator, disability plan and its administrator, insurer, and/or any other entity subject to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) that has provided treatment, service, or coverage within the past 10 years to disclose the entire medical, accident, and medical examiner records to 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) and the use of alcohol, drugs, and tobacco.

I understand 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, accident information, demographic information, and claims payment information.

I understand that unless prohibited by state and/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 medical, life, and disability coverages, and conduct other legally permissible activities that relate to any coverage 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 employment, employment history or income to Principal Life.

The following groups of persons employed or working for Principal Life may use 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 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: Life/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 complete medical, accident or medical examiner records, Principal Life may not be able to process the application for life and/or disability coverage, or if coverage has been issued, may not be able to make any such benefit payments. Upon your request, a copy of this completed authorization will be provided to you. Any alteration of this form will not be accepted.

Deceased's name: \_\_\_\_\_ Deceased's date of birth: \_\_\_\_\_

Representative's signature: \_\_\_\_\_ Date: \_\_\_\_\_

Representative's full name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Representative's address: \_\_\_\_\_

Representative's telephone number: \_\_\_\_\_ Claim number: \_\_\_\_\_

Representative's relationship to the deceased: \_\_\_\_\_