



Mailing Address: Des Moines, IA 50392-0001

Principal Life Insurance Company

Continuation Claim Form

Instructions

Please complete the first page of this form and have your doctor complete the Attending Physician's Statement.

Claimant's Statement

Name, Date of Birth, Telephone No., Address, Policy Number(s)

If you have NOT returned to work, complete this section. (A)

- 1. Are you currently totally disabled?
2. Please explain how your symptoms/medical condition continues to prevent you from working:
3. When do you expect to be able to return to work full-time part-time
4. Please provide the name, address and date seen of any other doctor or therapist...
5. Please indicate if you have applied for any of the following benefits:
6. Please indicate if you are receiving any of the following benefits:

If you HAVE returned to work, or PLAN to return to work, please complete this section. (B)

- 1. Date you returned or plan to return to work full-time part-time
2. Is this your regular occupation?
a. If Yes, please explain your current work activities...
b. When do you expect to be able to work full-time?

Fraud Statement: Any person who knowingly and with intent to defraud any insurance company or other person, submits a statement of claim or any application form 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.

I represent that the above statements on this claim form are true and complete to the best of my knowledge.

X Signature Date MM/DD/YYYY

Attending Physician's Statement

1. a. Diagnosis (including any complication)
- b. Subjective Symptoms:
- c. Objective Findings:
- d. Please provide the name, address and specialty of any other physician that has treated or evaluated the patient.

2. Dates of visits since the last form: _____ Date of next visit ____ / ____ / ____

3. NATURE OF TREATMENT (including type and date of surgery and medications prescribed, if any)

4. CARDIAC (complete only if applicable)

a. Blood pressure (last visit) Systolic _____ Diastolic _____

b. Class 1 (no limitation) Class 2 (slight limitation) Class 3 (marked limitation) Class 4 (complete limitation)

c. METS (circle 1) 1 2 3 4 5 6 7

5. Do you believe the patient is competent to endorse checks and direct the use of the proceeds thereof? Yes No

6. a. Are there limitations and restrictions to the patient's work activities solely due to their medical condition?
 Yes No

b. If yes, what are the specific limitations and restrictions to the patient's work activities?

c. Date restrictions began: _____ Date restrictions ended/or will end: _____

7. a. Do you expect a fundamental or marked change in the future? Yes No

b. (1) If yes, when will patient recover sufficiently to return to work?

1 mo. 1-3 mo. 4-6 mo. On ____ / ____ / ____

(2) If no, please explain. _____

8. REHABILITATION

a. Is patient a suitable candidate for medical rehabilitation? (i.e. cardiopulmonary program, speech therapy, etc.)

b. Would job modification enable patient to work with impairment? Yes No
 If yes, please explain. _____

c. Is the patient suitable for vocational rehabilitation? Yes No

d. What specific limitations and restrictions would you place on vocational rehabilitation? _____

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I represent that the above statements on this claim form are true and complete to the best of my knowledge.

Print Physician's Name	Degree	Specialty	Telephone
Street Address	City	State or Province	Zip Code

X

Signature _____

Date MM/DD/YYYY _____



Mailing Address:
Des Moines, IA 50392-0001

Principal Life
Insurance Company

Attending Physician's
Statement

Please fully complete this form. If incomplete, we will call you for the omitted information.

Patient Name _____ Date of Birth MM/DD/YYYY _____

Policy Number(s) _____

1. a) Diagnosis: (including any complication)

b) Subjective Symptoms:

c) Objective Findings: (including results and dates of testing)

2. Any previous occurrences of this condition? If so, please provide dates and details and describe past treatment, including any surgical procedures:

3. Does your patient have any chronic or recurring condition(s) not noted above? Please provide details or any other remarks:

4. DATES OF TREATMENT

Date of next visit / /
MM DD YYYY

5. NATURE OF TREATMENT (including type and date of surgery and medications prescribed, if any)

6. CARDIAC (complete only if applicable)

a. Blood pressure (last visit) Systolic _____ Diastolic _____

b. Class 1 (no limitation) Class 2 (slight limitation)
 Class 3 (marked limitation) Class 4 (complete limitation)

c. METS (circle one) 1 2 3 4 5 6 7

7. Is patient still under your care? Yes No If no, please explain:

8. Was patient referred by another physician? Yes No "If yes"

Name _____

Address _____

9. Is patient currently being treated by or referred to any other Doctor or Therapist? Yes No "If yes"

Name _____ Address _____

Name _____ Address _____

10. Was the patient hospitalized? Yes No "If yes"
 Date MM/DD/YYYY _____ Hospital _____
 Date MM/DD/YYYY _____ Hospital _____

11. a. Are there limitations and restrictions to the patient's work activities solely due to their medical condition?
 Yes No
 b. If yes, what are the specific limitations and restrictions to the patient's work activities?

 c. Date restrictions began: _____ Date restrictions ended/or will end: _____

12. Do you expect a fundamental or marked change in the future. Yes No
 (1) If yes, when will patient recover sufficiently to return to work?
 1 mo. 1-3 mo. 4-6 mo. On _____ / _____ / _____
MM DD YYYY
 (2) If no, please explain: _____

13. REHABILITATION

a. Is patient a suitable candidate for medical rehabilitation? (i.e. cardiopulmonary program, speech therapy, etc.)
 Yes No
 b. Would job modification enable patient to work with impairment? Yes No If yes, explain: _____

 c. Is patient a suitable candidate for vocational rehabilitation? Yes No
 d. What specific limitations and restrictions would you place on vocational rehabilitation? _____

14. Do you believe the patient is competent to endorse checks and direct the use of the proceeds thereof?
 Yes No

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PRINT Physician's Name	Degree	Specialty	Telephone
Street Address	City	State or Province	Zip Code

Signature _____ Date MM/DD/YYYY _____