Mailing Address:
Des Moines, IA 50392-0002

Principal Life Insurance Company

Steps to File a Claim

Submitting a Short-Term Disability Claim

Your ability to earn an income is one of your greatest assets. Your employer understands this and provides a Short-Term Disability (STD) program to help protect you and your family from income loss caused by an illness or injury.

How to Submit a Claim

At Principal Life, your claim specialists are as close as the nearest phone or computer. If an illness or injury prevents you from working, follow these steps:

- Consult your benefit booklet or your benefit department for the elimination period (the amount of time before benefits may be payable) associated with your coverage, and any deadlines for submitting claims.

- Sign, date and submit the Authorization form on the back of this document when your disability begins to authorize the release of information to our claims specialists. We cannot process your information without this form.

  Email, fax or mail a copy of the completed authorization to:

  Principal Life Insurance Company
  Attn: Life and Disability Claims
  Des Moines, Iowa 50392
  Fax: 800-255-6609
  Email: dlsbdclaims@exchange.principal.com

- Choose your preferred claim filing method:

  Phone
  Dial **866-825-1632** to speak with an intake specialist regarding your claim. The Call Service Center operates Monday – Friday 7:00 AM – 7:30 PM CST.

  Computer
  Log in to **www.principal.com,** and:

  - Click on **Individuals**, then place your cursor on **Insure.**
  - Under the **Get Started** section, click on **Get a Form**
  - Under **Filing claims for insurance through your employer**, click on **Submit a disability insurance claim online**
  - Then select "**employee**" to proceed.

Information Needed to File a Claim

Be prepared to provide the following information with your claim request. If someone else calls on your behalf, he or she will need:

- Name of your employer: **Stillwater Mining Company**
- STD Plan Number: **H71695**
- Your Location
- Your Name and ID Number
- Address and phone number
- Date of birth
- Occupation (or job title)
- Reason for the claim: illness, injury or pregnancy
- Physician's contact information
- Brief description of the reason for your claim
- Date of injury or beginning of illness
- Whether or not it's work-related
- Dates of treatment
- Last day worked and first day absent from work
- Date you expect to return to work (if known)
- Actual date if you have returned to work
- Restrictions or limitations advised by your health care provider(s)

What to Expect Once You Submit Your Claim

After your claim is submitted, the claims specialist will gather additional information from your employer and health care provider(s). If your claim is approved, you will begin receiving your weekly benefits from Principal Life.

You can expect a call from your Principal Life claim specialist to discuss the following in greater detail:

- Return-to-work intentions
- Proposed treatment plan
- Daily activities
- Social Security disability status
- Additional information needed

The focus for any claim is to look at immediate return-to-work opportunities in your regular job using:

- Job modification or restructuring
- On-the-job therapy to assist with work-related duties
- Possible temporary placement in another job until you can return to normal duties

We suggest filing up to 30 days in advance of a planned medical absence, such as pre-scheduled surgery or an expected maternity leave, to ensure your STD claim is ready when you need it.

The Authorization below gives your health care provider(s) the ability to release appropriate information about your condition to Principal Life for your Short-Term Disability claim. Sign and date the authorization when your disability begins. Show your health care provider(s) the document, and ask them to make a copy for your medical records. Be sure to email, fax or mail a completed copy of this authorization as requested on the reverse.

Authorization for Release of Personal Health Information

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 to disclose my entire medical record to the Principal Life Insurance Company (Principal Life), 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 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 medical and disability coverages, 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 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 complete medical record, Principal Life may not be able to process my application for life 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.

Claimant's signature: **X** _____ Date: _____ Claimant's

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

address: _____

Telephone number: (_____) _____ Can confidential messages be left at this number? yes no

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:

_____ **X** _____ _____

(Country) (Signature) (Date)