Laborers' District Council of Western Pennsylvania Welfare Fund STD Claim Filing Instructions

Simplifying the Claim Process

Your Short Term Disability (STD) is now administered by Principal Life Insurance Company. If you need to file for STD, submitting the claim is probably one of the last things on your mind. Principal Life has simplified the process with our Telephonic Claims Program. This program:

- Eliminates the paperwork involved in submitting claims
- Streamlines the claim process
- Ensures your claim receives prompt attention

Submitting Claims by Phone

With the Telephonic Claims Program, our intake specialists are as close as the nearest phone. Just call our toll-free phone number to begin the claim process, and we'll take care of the rest.

How to Report a Claim

If an illness or injury prevents you from working, follow these steps:

1. Follow your Laborers' District Council of Western Pennsylvania Welfare Fund procedures for reporting your absence.

2. Consult your Summary Plan Description 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 your claims.

3. Sign and date the authorization when your disability begins. Show the authorization to your Health Care Provider(s) and ask them to make a copy for their records. That document will authorize them to release information to our Claim Specialists so we can process your claim.

4. Call us at our toll-free claim number: **1-877-257-6978**. An Intake Specialist will ask you for information about you, your disability, employment and Health Care Provider(s) to begin the claim process.

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

Information Needed to File a Claim

The following information may be required when you make your claim request. Please be prepared. If someone else makes the call on your behalf, he or she will need to provide this information:

- Name of your employer
- Policy number: H66085
- Your name and Social Security Number
- Complete address, phone number and e-mail address (if applicable)
- Date of birth
- Marital Status
- Occupation (or job title)
- Reason for the claim:
- Location you are employed
- Physician's name, address, fax and phone number
- A brief description of your leave, which may include a summary of your condition including cause of condition (injury/illness), date of injury or beginning of illness, and whether or not it's work-related
- The dates of your first visit, your most recent visit and your next scheduled visit with your physician for this condition
- Your last day worked and your first day absent from work due to this condition
- The date you expect to return to work (if known), or the actual date if you have already returned to work at the time of your call
- Work restrictions or limitations advised by your physician, (if applicable)

How to Report a Claim

Call Principal to submit your claim at **1-877-257-6978**

Monday through Friday, 6 a.m. to 7 p.m. Eastern Standard Time, or log in to: www.principal.com. You can also call this number to check the status of your claim.

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The Authorization below provides helpful information if a disability occurs. It 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. Please also Fax or mail a completed copy of the authorization to:

Principal Life Insurance Company
Attn: Life and Disability Claims
Des Moines, IA 50392
Fax: 1-800-255-6609

Authorization for Release of Personal Health Information

Attention Medical Provider: Your patient's income continuation depends on evaluation of their disabling condition. Please keep a copy of this authorization. A claims specialist from Principal Life will be contacting you soon.

I hereby authorize my health care provider, health plan, insurer or any other entity subject to HIPAA to release to Principal Life Insurance Company, its agents, employees, insurance support organizations, reinsurers, and their representatives, my entire medical record. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection, sexually transmitted diseases, mental illness (excluding psychotherapy notes as defined under HIPAA) and the use of alcohol, drugs, and tobacco. This personal health information will be used by employees and others working on behalf of Principal Life for the purpose of determining my eligibility for disability insurance benefits.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information (PHI) do not apply to this authorization and instruct my health care provider, health plan, insurer or any other entity subject to HIPAA to release and disclose my medical record without restriction. I understand any information disclosed pursuant to this authorization may no longer be covered by the privacy provisions of HIPAA and may be subject to redisclosure.

This authorization will terminate one year after the date signed. The authorization may be revoked by me, in writing to: Health Information Protection Analyst, Group Compliance, Principal Life Insurance Company, Des Moines, IA, 50392-0002. I understand that a revocation is not effective if Principal Life has relied on the PHI 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 and/or disability coverage**, or if coverage has been issued, may not be able to make any such benefit payments. I acknowledge that I have received a copy of this authorization.

Employee Name: _____
(Please Print)

Employee Signature: _____

Social Security Number: _____

Date of Birth: _____

Date: _____

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