

**J. R. Simplot Company
Benefit Plan No. N29196**

Administered by
Principal Mutual Life Insurance Company
Des Moines, Iowa

Medical/Dental/Vision Claim

Please mail completed form to:
Principal Life Insurance Company P.O. Box 39710 Colorado Springs, CO 80949-3910
Telephone (Toll Free) Nationwide 1-800-894-9576

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. Such actions may be considered felonies and subject to criminal and civil penalties, including imprisonment and fines.

Instructions:
1. Complete this form.
2. Attach all bills and keep a copy for your records.

Part I: Type of Claim

Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/>	\$ _____ Total of all bills submitted
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Part II: Employee

Employee's Name:	Employee's Social Security Number:
Employee's Address: (Street, City, State, Zip)	

Part III: Patient

Patient's Name:	Patient's Date of Birth: (Month/Day/Year)	Relationship to Employee: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Stepchild <input type="checkbox"/> Foster Child <input type="checkbox"/> Full-time Student <input type="checkbox"/> Not in School
Were expenses related to accident? <input type="checkbox"/> Yes <input type="checkbox"/> No Was accident employment related? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If yes, describe when, where, what happened: _____		

If this claim is for vision benefits, please indicate: Lens Frames Exam
 Attach payment receipt or cash register receipt to claim form if prescription is being filled by someone other than the examining physician or optometrist.

Does Patient or Employee have other insurance? Yes No If Yes, complete information below:

Name of Insurance Company	Address of Company:	Policy Number:
Is Employee;s spouse employed? <input type="checkbox"/> Yes <input type="checkbox"/> No		If Yes give name, address and telephone number of spouse's employer:

If patient is covered by spouse's plan or any other medical plan, group policy, prepayment plan, Medicare or other Government plan, please provide the following information: Name of Person(s) carrying the other coverage: _____

Part IV: Authorization

In order to process a claim for benefits, I authorize any physician, hospital or other medical provider to release to Principal Life Insurance Company and the planholder, or their representatives, any information regarding my medical history, symptoms, treatment, examination results or diagnosis. A photocopy of this authorization shall be considered as effective and valid as the original. This authorization shall be considered valid for the duration of the claim, but not to exceed one year from the date signed. I understand I have the right to receive a copy of this authorization.

I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO THE PHYSICIAN OR SUPPLIER FOR THE SERVICES DESCRIBED: Yes No

Date: _____ Signature of Employee: _____

Signature of Patient: _____
(Required only if patient is spouse)