



Underwritten by
United of Omaha Life Insurance Company
A Mutual of Omaha Company

Group Insurance Claims Management
3300 Mutual of Omaha Plaza
Omaha, NE 68175-0001
Toll Free (833) 928-2179
Fax (402) 997-1878
Email submitgroupPFML@mutualofomaha.com

A Guide for Successfully Completing the Group Oregon Paid Family and Medical Leave Claim Form

Mutual of Omaha appreciates the opportunity to provide you with valuable income protection. We rely on the information you provide on this form to effectively determine if you qualify for group paid leave benefits.

This guide provides information and instruction to help you successfully complete and submit the claim form. Please consult your employer/benefits administrator if you need assistance in providing information for the form.

Important Tips for Paper Copy Submission

- Prior to submission, make sure you have provided all required information and answered all questions completely and accurately. If information is missing or cannot be read, the processing of your form may be delayed.
- The following guidelines provide valuable information to help you successfully complete the form.
- Please make a copy of the completed form for your records before submitting it to Mutual of Omaha/United of Omaha.

Guidelines for Section 1: Employee Statement

This section is to be completed by the Employee. Dates should include the month, date and year. In order to be considered complete, the form must be signed by you.

- The type of leave requested is where you indicate whether the leave is for your own serious health condition, bonding time with your child, leave to care for a family member with a serious health condition, or safe leave to address needs related to domestic violence, sexual assault, harassment, or stalking.
- Continuous leave is time off with no periods of return to work; intermittent leave is time off that will be taken for a short period at a time over several months.

Documentation to include for each type of leave

Please include the requested documentation with your claim form to prevent any delay in processing.

Your own Serious Health Condition or the Serious Health Condition of a family member

- If for your own health condition, a certification completed by your treating physician or health care provider
- If you are taking leave to care for a family member with a serious health condition, a certification completed by the family member's treating physician or health care provider

Family Leave to Care for and Bond with a Child During the First Year After Birth

- the child's birth certificate; or
- a consular report of birth abroad; or
- a statement from the health care provider of the child or pregnant parent; or
- a hospital admission form associated with delivery

Family Leave to Care for and Bond with a Child During the First Year After Placement Through Foster Care or Adoption

- a copy of a court order verifying placement; or
- a letter signed by the attorney representing the prospective parent that confirms the placement; or
- a document from the agency or social worker involved in the placement that confirms the placement; or
- a document for the child issued by the United States Citizenship and Immigration Services

Safe Leave

- a copy of a federal agency or state, local, or tribal police report, or a formal complaint indicating that you or your child was a victim of domestic violence, harassment, sexual assault, or stalking; or
- a copy of a protective order or other evidence from a federal, state, local, or tribal court, administrative agency, or attorney that you or your child appeared in or was preparing for a civil, criminal, or administrative proceeding related to domestic violence, harassment, sexual assault, or stalking; or
- documentation from an attorney, law enforcement officer, health care provider, licensed mental health professional or counselor, member of the clergy, or victim services provider that you or your child was undergoing treatment or counseling, obtaining services, or relocating as a result of domestic violence, harassment, sexual assault, or stalking

If you cannot provide one of the above forms of documentation, you may instead provide a written attestation that you are taking eligible safe leave.

Authorization to Disclose Personal Information & Authorization to Disclose Health Information to My Employer

Both authorizations are to be completed by the Employee. Dates should include the month, date and year. In order to be considered complete, the form must be signed by you or your legal representative.

- By signing the authorization, you are applying for paid family or medical leave benefits with United of Omaha and are agreeing to allow disclosure of personal information to the necessary parties for the purpose of claim processing.
- If the name associated with any of your medical records differs from the name provided on the form, provide any alternate names. This might occur in the event of a name change due to marriage or adoption.

Guidelines for Section 2: Paid Family Leave

This section is to be completed by the Employee if applying for paid family leave benefits to care for a family member's serious health condition. Dates should include the month, date and year. In order to be considered complete, the form must be signed by you.

- Provide all requested information about the family member for whom you are requesting leave.
- Briefly explain the reason the family member requires care.
- Provide the name and contact information for the family member's physician or health care provider.

Guidelines for Section 3: Certification of a Serious Health Condition

This section is to be completed by the physician or health care provider who is certifying a serious health condition or pregnancy. Dates should include the month, date and year. In order to be considered complete, the form must be signed by the physician/health care provider. This form should be submitted with either a paid family leave to care for a family member with a serious health condition or a paid medical leave claim.

Guidelines for Section 4: Employer's Statement

This section is to be completed by the Employer. Dates should include the month, date and year. In order to be considered complete, the form must be signed by the Employer.

- Group ID Number consists of eight characters, beginning with "G000" and followed by four additional letters or numbers.
- Employee wages should include gross quarterly wages.
- Provide days and hours the Employee normally worked.
- Indicate the date the claim form was received from the Employee.
- Note any time off the Employee has taken in the last 52 weeks.
- Indicate if you are continuing to pay wages and are seeking reimbursement of benefit rather than us paying benefits to the employee.



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Section 1 – Employee Statement (Answer all questions to avoid delay)

What type of claim is being filed? (check all that apply) ☐ OR PFML ☐ STD ☐ LTD

Current Employer's Name

Employee Name

Employee Address

Employee City

Employee State

Employee ZIP

Employee (Area Code) Telephone Number

Employee Social Security Number

Employee Email Address

Employee Date of Birth

What type of leave are you requesting? (check boxes for each of the below)

☐ Own serious health condition – If own serious health condition,
please describe your health condition:

☐ Pregnancy – Expected due date _____

☐ Serious health condition of a family member.

Your relationship to family member: _____
Please complete Section 2 if selecting this option.

☐ Adoption/foster a child placement date: _____

☐ Bonding: Child's birth date: _____

☐ Organ or Bone Marrow donor

☐ Safe leave

Are you working for another employer? ☐ Yes ☐ No If "Yes," please provide the information below:

Occupation

Date of hire

Days worked per week

Hours worked per day

Average weekly wage

Health Care Provider Information (to be completed by the care recipient or authorized representative)

Identify the health care provider who is currently providing you with treatment for a condition that is subject to the employee's request for PFL benefits.

Health care provider's name

Health care provider's mailing address

City

State

ZIP

Country (if not U.S.A.)

Health care provider's telephone number (provide area or country code)

Health care provider's fax number (provide area or country code)

Employment Information

Job Title	Last Day at Work	First Work Day Missed
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Has any time been missed prior to this occurrence for paid medical or family leave? If "Yes," what was the reason for leave?	☐ Yes ☐ No	Dates of leave	Type of leave: ☐ PFL ☐ PML
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Work Address (If you work from home, home address)	City	State	ZIP
--	------	-------	-----

Leave schedule:

☐	Continuous	Leave start date (MM/DD/YYYY) □□ / □□ / □□□□	Leave end date (MM/DD/YYYY) □□ / □□ / □□□□	☐ Dates are estimated
☐	Intermittent	Identify dates intermittent leave will be taken: _____		☐ Dates are estimated

Estimated Return to Work Date

If providing less than 30 day's advance notice to the employer, please explain:

Other Income Sources: ☐ Workers' Compensation ☐ Vacation/PTO/Sick/PFML ☐ Salary Continuation

Please provide dates of other income received (MM/DD/YYYY): From _____ to _____

Information For Federal Income Tax Withholding If your request for benefits is approved, should Mutual of Omaha/United of Omaha withhold income taxes from your benefit checks?

☐ Yes ☐ No If "Yes," how much should be withheld from each check (the minimum is \$20.31 per week). \$_____.00

Note: Please enter a full dollar amount and not a percentage.

Signature (Required for all claims.)

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.

The above statements are true and complete to the best of my knowledge and belief.

X _____
Signature of Employee

Date

Authorization to Release Personal Information

1. I (the undersigned) authorize any physician, medical or dental practitioner, pharmacist, other health care provider, hospital, clinic, or medical facility, insurer, reinsurer, insurance services support organization, employer, government agency, consumer reporting agency, or insurance policy or benefit plan administrator to release records containing the Personal Information of:

Name of Claimant _____
(Last) (First) (Middle)

Date of Birth ____ / ____ / ____ Social Security Number ____ - ____ - ____

This medical or health information may include information on the diagnosis and treatment of mental illness, alcohol, and drug use. This also may include information on the diagnosis, treatment, and testing results related to HIV, AIDS, and sexually transmitted diseases, unless otherwise restricted by state law.

2. **Personal Information to be released:**

- data or records regarding my medical history, treatment, prescriptions, consultations (including medical and psychological reports, records, charts, notes (excluding psychotherapy notes), X-rays, films or correspondence, and any medical condition I may now have or have had including the presence of HIV infection, AIDS or ARC;
- any information regarding insurance or benefit plan coverage, claims or benefits; and/or
- any information, data or records regarding my activities (including records relating to my Social Security, Workers' Compensation, retirement income, financial information, earnings and employment history)

3. **You may release my Personal Information to:**

Group Disability Management Services
Mutual of Omaha Insurance Company/United of Omaha Life Insurance Company
3300 Mutual of Omaha Plaza
Omaha, NE 68175-0001
or Fax: 402-997-1878 or Email: submitgroupPFML@mutualofomaha.com

4. **I understand my Personal Information will be used by Mutual to evaluate my claim for benefits, or as required or permitted by law, and that if I refuse to sign this Authorization, my claim for benefits may not be paid. I also authorize Mutual to release my Personal Information as follows:**

- to its reinsurer, or other persons or organizations performing business, legal or insurance support services in connection with my claim(s); or
- to a vendor specializing in the application for Social Security Disability Benefits; or
- to vendors/consultants providing me with wellness, disability or leave related services as part of an employer sponsored benefit plan; or
- for self-insured disability plans only, to my employer; or
- for fully insured plans to my employer for use in discussions with Mutual regarding my functional capacity, and any related restrictions and limitations, in order to facilitate my return to work; or
- as otherwise required or permitted by law or as I further authorize

5. I understand my Personal Information may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

6. I understand that I may revoke this Authorization at any time by providing a written request to Mutual at the address above. If I revoke this Authorization, it will not affect any use or disclosure of Personal Information that occurred prior to Mutual's receipt of my revocation. If written revocation is not received, this Authorization will remain valid until 24 months after the date signed, except that disclosure of HIV-related information is authorized for 180 days from the date I sign it.

7. I understand that I am entitled to receive a copy of this Authorization and that a copy is as valid as the original.

RETAIN A SIGNED COPY FOR YOUR RECORDS

Name(s) used for records (if different than the name below): _____

Signature of Claimant

Date

If Applicable: I am the legal representative of the Claimant and I am authorized to grant permission on behalf of the Claimant.

Printed Name of Legal Representative _____

Signature of Legal Representative _____

Type of Legal Representative _____

THIS AUTHORIZATION COMPLIES WITH HIPAA AND OTHER FEDERAL AND STATE LAWS

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Electronic Funds Transfer (EFT) Authorization

Direct Deposit of Benefit Payments

I understand that by completing this form, I am authorizing United of Omaha Life Insurance Company to directly deposit into my bank account via Electronic Funds Transfer (EFT) payment(s) due to me under a contract issued by United of Omaha to my financial institution with the information provided below, for credit to my account. I represent that the bank information listed below is not affiliated with a prepaid banking card or a non-standard checking/savings account, and I understand that such prepaid banking card or non-standard checking/savings accounts are not accepted by United of Omaha.

Furthermore, I authorize and direct the bank to charge said account or the account of my estate for any payment made in error as determined by United of Omaha and to refund any such payment made subsequent to my death or made in error and to refund any such payment to United of Omaha upon its written request to the bank.

I further understand and agree that it is my responsibility to ensure that all bank information reported on this form is accurate and correct for the appropriate deposit of my payment(s) and that United of Omaha can rely on this information and will have no obligation to ensure the correctness of the information. Completion of this form is not a guarantee that benefits will be paid.

I further understand and agree that any payment(s) made into an incorrect bank account (including, without limitation, to a prepaid banking card or non-standard checking/savings account, both of which are not accepted by United of Omaha) pursuant to the information reported on this form, will be forfeited by me and that United of Omaha has no obligation to retrieve those funds or make replacement payment(s) to me.

I further understand and agree for myself, my heirs, executors and estate to indemnify and hold United of Omaha harmless from any and all loss or damage of any nature whatsoever, including costs or attorney's fees incurred by reason of said bank acting pursuant to this Authorization.

I further understand and agree that United of Omaha is not responsible for any bank charges or other costs associated with or arising out of this agreement.

I further understand that if my bank is not able to accept EFTs, checks will be mailed to my residence.

I reserve the right to revoke and cancel this authorization. Such revocation and cancellation shall be effective within 5 business days following United of Omaha's receipt of the notice.

Payee Information	Bank Information
Full Name	Bank Name
Address	Address
Address	Address
City	City
State and ZIP Code	State and ZIP Code
Telephone Number ()	Telephone Number ()
Social Security Number	Account Number
Policy Number	Bank ABA Routing/Transit Number
Claim Number	☐ Checking (Check only one) Prepaid banking cards and non-standard checking/savings accounts not permitted. ☐ Savings
Payee Number (for office use only)	Approved By/Date (for office use only)

X _____
Payee Signature Date

Contact Information

Please attach EITHER a voided check for checking OR a deposit slip for savings and return with this form to:

United of Omaha Life Insurance Company
HO8W-GDMS
3316 Farnam Street
Omaha, NE 68172-7420

You may also fax to 402-997-1878 or email to submitgroupPFML@mutualofomaha.com

Should you have any questions regarding EFT, please feel free to contact our customer service representatives toll free at **1-833-928-2179** (Monday-Thursday 7 a.m.-5:30 p.m. and Friday 7 a.m.-5 p.m. CST).

Fraud Warnings

Required Fraud Warnings (State specific warnings apply to the resident of such state)

Fraud Warning: 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.

Alabama: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

Arkansas/Kentucky/Louisiana/Maine/New Mexico/Ohio/Tennessee: Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

California: For your protection, California law requires the following to appear on this form. Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a 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.

Kansas: 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 as determined by a court of law.

Maryland: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully 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 York: 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Oregon: 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 may be a crime and may subject such person to criminal and civil penalties.

Puerto Rico: Any person who furnishes information verbally or in writing, or offers any testimony on improper or illegal actions which, due to their nature constitute fraudulent acts in the insurance business, knowing that the facts are false shall incur a felony and, upon conviction, shall be punished by a fine of not less than five thousand (5,000) dollars, nor more than ten thousand (10,000) dollars for each violation or by imprisonment for a fixed term of three (3) years, or both penalties. Should aggravating circumstances be present, the fixed penalty thus established may be increased to a maximum of five (5) years; if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

Rhode Island: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information on an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Vermont: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claims containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto may be committing a fraudulent insurance act, which may be a crime and may subject such person to criminal and civil penalties.

Virgin Islands: 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 penalties.

Virginia: Any person who, with the intent to defraud or knowing that he 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.

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Section 2 - Paid Family Leave

This section is only to be completed for paid family leave, not paid medical leave. TO BE COMPLETED BY THE EMPLOYEE

Employee's name (first name, middle initial, last name)

Care recipient's (patient's) name (first name, middle initial, last name)

Care recipient's (patient's) date of birth (MM/DD/YYYY)

		/			/				
--	--	---	--	--	---	--	--	--	--

Is leave requested due to a family member's serious health condition? ☐ Yes ☐ No

What is your relationship to the family member?

What is the requested start date of leave for the family member's serious condition?

What is the anticipated duration of the family member's serious health condition?

Does the family member with the serious health condition require your assistance? ☐ Yes ☐ No If "Yes," please explain.



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Section 3 – Certification of a Serious Health Condition (PFL or PML) TO BE COMPLETED BY THE PHYSICIAN OR HEALTH CARE PROVIDER

Name of person applying for leave:		Name of person's date of birth (MM/DD/YYYY)	
Employee Address	Employee City	Employee State	Employee ZIP
Employee (Area Code) Telephone Number		Employee Date of Birth	

Family Leave

Instructions: Please complete this section if the patient is a family member of the employee.

Patient's name: (first name, middle initial, last name)	Patient's date of birth (MM/DD/YYYY)

If leave is for care of a family member please answer: Will the employee be required to take leave to care for the patient? ☐ Yes ☐ No

The patient must have a serious health condition for the employee to qualify for Paid Family and Medical Leave. Please complete the Serious Health Condition and Treatment Plan sections in relation to the patient's medical condition. Please complete the Leave Schedule section in relation to the employee's need for leave to care for the patient.

Serious Health Conditions

- If applicable, briefly describe other appropriate medical facts related to the condition(s) or medical diagnosis for which the employee seeks PFML leave.
(Ex., symptoms, hospitalizations, referrals for evaluation or treatment)
- Check the box(es) for the questions below, as applicable. For all box(es) checked, the amount of leave needed must be provided in the Required Leave Section.

- ☐ **Inpatient Care:** The patient (☐ has been / ☐ is expected to be) admitted for an overnight stay in a hospital, hospice, or residential medical care facility on the following date(s)
- ☐ **Incapacity plus Treatment:** (e.g., outpatient surgery, strep throat) Due to the condition, the patient (☐ has been / ☐ is expected to be) incapacitated for more than three consecutive, full calendar days from (MM/DD/YYYY) to (MM/DD/YYYY).
The patient (☐ was / ☐ will be) seen on the following date(s)
- ☐ **Pregnancy:** The condition is pregnancy. List the expected delivery date (MM/DD/YYYY).
If the employee has already delivered, delivery date and type (MM/DD/YYYY) ☐ Cesarean Section ☐ Vaginal
If there are any pregnancy complications, please indicate

Briefly describe the incapacity due to postnatal serious health condition. Can include but is not limited to recovery after a cesarean delivery, infections, or other postnatal complications.

Provide the start and end dates for the leave needed for the serious health condition described above. Do not include bonding leave, which may be applied for separately.

Start date: (Child's date of birth) (MM/DD/YYYY) End date: (MM/DD/YYYY)

- ☐ **Chronic Conditions:** (e.g., asthma, migraine headaches) Due to the condition, it is medically necessary for the patient to have treatment visits at least twice per year. Date the condition started (MM/DD/YYYY)
- ☐ **Permanent or Long-Term Conditions:** (e.g., Alzheimer's, terminal stages of cancer) Due to the condition, incapacity is permanent or long term and requires the continuing supervision of a health care provider (even if active treatment is not being provided).
- ☐ **Conditions requiring Multiple Treatments:** (e.g., chemotherapy treatments, restorative surgery) Due to the condition, it is medically necessary for the patient to receive multiple treatments.

- ☐ **Imminent Danger or Death:** (e.g., Terminal prognosis) Due to the condition, the condition poses an imminent danger of death, or that is terminal in prognosis with a reasonable possibility of death in the near future.
- ☐ **Organ or Bone Marrow Donor:** The patient
(☐ has been / ☐ is expected to be) donating an organ or bone marrow. Surgery date(s) _____ (MM/DD/YYYY)
- ☐ **None of the above:** If none of the above condition(s) were checked, (i.e., inpatient care, pregnancy) no additional information is needed.
Go to page 4 to sign and date the form.

3. Will this condition result in a course of continuing treatment under supervision of a health care provider (e.g., prescription medication other than over-the-counter, therapy requiring special equipment)? _____
4. Will the patient be treated 2 or more times per year for this condition? _____
5. Is the health condition work related? ☐ Yes ☐ No

Required Leave Needed

For the medical condition(s) checked in the Serious Health Conditions above, complete all that apply. Several questions require a response as to the frequency/duration of a condition, treatment, etc. Your answer should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can; terms such as "lifetime," "unknown," or "indeterminate" may not be sufficient to determine PFML coverage.

Treatment Plan

- A) Due to the condition: the patient (☐ had / ☐ will have) planned medical treatment(s) (scheduled medical visits) (e.g., psychotherapy, prenatal appointments) on the following date(s) _____
- B) The patient (☐ was / ☐ will be) referred to other health care provider(s) for evaluation or treatment(s). _____
- C) Provider name and phone and fax number, if applicable _____
Referral area of specialty _____

Leave Schedule

Continuous

- A) Will the patient need leave on a continuous basis? ☐ Yes ☐ No
- If "Yes," provide your best estimate of the beginning date _____ (MM/DD/YYYY) and end date _____ (MM/DD/YYYY) for the period of incapacity.

Intermittent

- A) Will the patient need leave on an intermittent basis? ☐ Yes ☐ No
- B) Provide your best estimate of the beginning date _____ (MM/DD/YYYY) and end date _____ (MM/DD/YYYY) for intermittent leave.
- C) Episodes of incapacity are estimated to occur _____ times per (☐ day / ☐ week / ☐ month) and are likely to last approximately _____ (☐ days) per episode.

PROVIDER'S INFORMATION AND CERTIFICATION

I declare under penalty of perjury that the information provided in this form is true and correct, that the patient's condition causes an incapacitation from work and that I am a healthcare provider authorized to certify their condition.

Signature _____		Date _____
Name and title _____		
Certificate license and state _____	License area/area of practice _____	
Business name _____		
Address _____		
Phone number _____	Email address _____	Fax number _____



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Section 4 - Employer's Statement (Answer all questions to avoid delay)

What type of claim is being filed? (check all that apply) ☐ OR PFML ☐ STD ☐ LTD

Company Name

Group ID Number

Class No. or Description

Division/Location No. or Description

Effective Date of STD or LTD coverage, if applicable

Address

City

State

ZIP

Employee's Name

Employee's Phone Number

Employee Address

Employee City

Employee State

Employee ZIP

Employee Date of Birth

Employee Social Security Number

Employee Date of Hire

Employee's Job Title

Employee Wages Please complete this section based on the 5 completed quarters prior to leave filing.
(if less than 5 quarters are available, please also include any earnings from the current quarter for financial eligibility review)

Quarter No.	Quarter Ending Date (MM/DD/YYYY)	Gross Amount Paid	Average Hours Worked Per Week (ex. 40 hrs)	Check Days Normally Worked/Hours Worked
1				☐ Monday Hours Worked _____ (for each day)
2				☐ Tuesday Hours Worked _____ (for each day)
3				☐ Wednesday . . . Hours Worked _____ (for each day)
4				☐ Thursday Hours Worked _____ (for each day)
5				☐ Friday Hours Worked _____ (for each day)
				☐ Saturday Hours Worked _____ (for each day)
				☐ Sunday Hours Worked _____ (for each day)

Please indicate the percentage of PML contributions paid by the employee post-tax. _____

Last Day at Work

First Work Day Missed

Has the employee returned to work?

If "Yes," when?

☐ Yes ☐ No

Reason for leave:

Date employee notified of need for leave

☐ Employee's own Medical ☐ Family leave

Has the employee been terminated?

If "Yes," date of termination.

☐ Yes ☐ No

Is this disability work related? ☐ Yes ☐ No

If "Yes," was worker's compensation filed? ☐ Yes ☐ No

If the employee received or will receive full wages, will employer be requesting reimbursement?

☐ Yes ☐ No If "Yes," please answer the following questions: Amount paid? _____ Date benefits begin? _____ Date benefits end? _____

Please indicate the type of wages received:

In the preceding 52 weeks has the employee taken leave for:

☐ Self ☐ Family Member

Enter total number of weeks and days

taken for PFML in the last 52 weeks: Weeks _____ Days _____

If employee also has STD coverage, please provide the following:

Was the employee furloughed or laid off within the past 12 months? ☐ Yes ☐ No If "Yes," please provide the dates the employee was not Actively Working and the date they returned to Active Work.

Dates Employee was not Actively Working _____ Date Employee returned to Active Work _____

Were premiums paid during the furlough or lay off? ☐ Yes ☐ No

Did the claimant have prior STD coverage with another carrier while employed with you? ☐ Yes ☐ No

If "Yes," date the coverage was effective and name of prior carrier. Effective date_____ Name_____

Important Notice: For Employees age 60 or over, refer to the policy provisions regarding group life continuation and conversion rights.

If the employee is no longer working the minimum hours required under the policy, indicate why:

☐ Termination ☐ Layoff ☐ Personal Leave of Absence ☐ Medical Leave of Absence (e.g., FMLA) ☐ Other (explain)_____

Earnings under the STD policy (if applicable)	Does the employee contribute toward the premium? ☐ Yes ☐ No	If "Yes," what percent is paid by the employee?	Is it pre-tax or post-tax? ☐ Pre-tax ☐ Post-tax	Gross up? ☐ Yes ☐ No
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Signature (Required for all claims.): 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. The above statements are true and complete to the best of my knowledge and belief.

Print Name	Signature of Person Completing Claim Form		
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Title of Person Completing Claim Form	Phone Number	Email Address	Date Signed
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