



The Standard[®]

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**Applying For
Colorado Paid Family And Medical Leave (CO PFML)**

**To Use Colorado Paid Family And Medical Leave To:
Bond with a newborn, a newly adopted or fostered child**

Complete Form CO PFML -1

- Complete CO PFML-1, Part A
- Provide CO PFML-1 to employer
- Employer completes CO PFML-1, Part B and returns to you within 3 days

Complete Form CO PFML -2

- Complete CO PFML-2 and collect supporting documentation

Send forms and documents

- Send completed forms and supporting documentation to The Standard
- The Standard accepts or denies claim within 5 days once a complete claim is received.

Please keep a copy of all pages for your records.

- To request Colorado Paid Family And Medical Leave (CO PFML), the employee requesting CO PFML must complete Part A of the *Request For Colorado Paid Family And Medical Leave* (Form CO PFML-1). All items on the form are required unless noted as optional. The employee then provides the form to the employer to complete Part B.
- The employer completes Part B of the *Request For Colorado Paid Family And Medical Leave* (Form CO PFML-1) and returns it to the employee within three days.
- Additional forms are required depending on the type of leave being requested. The employee requesting leave is responsible for the completion of these forms.
- The employee submits the completed *Request For Colorado Paid Family And Medical Leave* (Form CO PFML-1) with the required additional form to The Standard. The employee should retain a copy of each submitted form for their records.

PART A - EMPLOYEE INFORMATION (to be completed by the employee)

The employee requesting CO PFML must complete all required information.

Colorado Paid Family And Medical Leave (CO PFML) Request (to be completed by the employee)

Question 9: Bond with child means to care for and bond with a Child during the first year after the Child's birth.

Adoption/Foster child means to care for and bond with a Child during the first year after the placement of the Child through Foster Care or adoption.

Care for Family Member with a Serious Health Condition means physical or psychological assistance as used for leave taken to care for a Family Member with a Serious Health Condition.

Safe leave means any period of leave because the Covered Individual or the Covered Individual's Family Member is the victim of Domestic Violence, the victim of Stalking, or the victim of sexual assault or abuse.

Military exigency means a period of leave needed to accommodate a Family member on active duty military service or being called to active duty military service.

Own Serious Health Condition due to pregnancy means any period of disability due to pregnancy or childbirth or related complications.

Own Serious Health Condition (other) means an illness, injury, impairment, or physical or mental condition of an Eligible Employee.

Question 10: Family Member means a Child, Parent, Spouse, Grandparent, Grandchild or Sibling; or any other individual with whom the Covered Individual has a significant personal bond that is or is like a family relationship.

Child means biological children (regardless of age), step-children, legal wards, or a child to whom the employee stands in loco parentis to the employee or the employee's spouse or domestic partner when they were minors.

Grandchild means a child of the employee's child.

Grandparent means a parent of the employee's parent.

Parent means the biological, step-parent, or an individual who stood in loco parentis to the employee or the employee's spouse or domestic partner when they were minors.

Sibling means the Covered Individual's, or the Covered Individual's Spouse's sibling or step-siblings.

Spouse means a husband or wife or domestic partner of an employee.

Significant Personal Bond means any other individual with whom the covered individual has a family relationship, regardless of biological or legal relationship.

The following factors will be considered:

- Shared financial responsibility, including shared leases, common ownership of real or personal property, joint liability for bills, or beneficiary designations;
- Emergency contact designations;
- The expectation of care created by the relationship;
- Cohabitation and the duration thereof; and
- Geographical proximity.

Question 11: If dates are "Continuous", the employee must provide the start and end dates of the requested CO PFML. These dates should be the actual dates that the CO PFML will begin and end. If uncertain, estimate the start and end dates and indicate "Dates are estimated".

If dates are "Intermittent", enter the dates CO PFML will be taken. Please be as specific as possible. If the dates are unknown or estimated, indicate "Dates are estimated".

If the employee is working a consistent but reduced work schedule for multiple weeks, provide the days/hours of leave needed for CO PFML. If uncertain, estimate the frequency of leave and indicate "Dates are estimated".

Question 12: Date employer was notified. If the employee is submitting the CO PFML request to their employer with less than 30 days' advance notice from the start date of the CO PFML, the employee must explain why 30 days' notice could not be given. If the explanation will not fit in the space provided on the form, enter "See Attached" and add an attachment with the explanation. Be sure to include the employee's full name and their date of birth at the top of the attachment.

Employment Information (to be completed by the employee)

Question 14: Enter the date of hire to the best of the employee's recollection. If it has been more than a year since the date of hire, entering the year in which employment started is sufficient.

Question 19: List all other income you will be receiving while on CO PFML. Include the type/name of income and how much. Example PTO from employer for \$500.00 a week.

**Payment for approved claims will be due 14 calendar days from the date of the claim decision.
Employee signs and dates, before giving this form to their employer to complete Part B.**

PART B - EMPLOYER INFORMATION (to be completed by the employer)

The employer of the employee requesting CO PFML must complete all information in Part B.

Question 2: If a Social Security Number is used for the Federal Employer Identification Number (FEIN), enter the Social Security Number.

Question 8: "Wages" include, but are not limited to, salary, wages, tips, commissions, and other compensation.

"Average Weekly Wage" means the Covered Individual's weekly Wages in effect with the Employer on the Day immediately preceding the date PFML begins.

For Covered Individuals who are paid hourly, the Average Weekly Wage is based on the hourly pay rate multiplied by the number of hours regularly scheduled to work for the Employer per week. If the Covered Individual does not have regular work hours, the Average Weekly Wage is based on the average number of hours worked per week for the Employer during the preceding 52 calendar weeks (or during the period of Employment with the Employer if less than 52 weeks). If a Covered Individual is paid on an annual contract basis, the Average Weekly Wage is based on one-fifty-second (1/52nd) of the Covered Individual's annual contract salary with the Employer.

Question 9: Regular Work Schedule means the Days of the week and the number of hours typically worked by the Covered Individual in the job or jobs held by the Covered Individual as of the first date of the PFML. Regular work schedule shall be determined by taking an average of the schedule worked during the 4 weeks prior to the last Day worked. If the Covered Individual has worked fewer than 4 weeks, the average shall only include the weeks in which the Covered Individual was employed by the Employer. For purposes of calculating a regular work schedule, Days missed due to paid sick leave, paid time off, holiday pay, or other Employer-provided leave must be included.

Question 11: Wage Continuation is an employer's continued payment of an employee's regular salaried wages during a period of PFML leave.

Internally sponsored paid family and medical leave is a separate bank of time off solely for the purpose of paid family and medical leave provided by an employer which may only be used for CO PFML qualifying reasons.

Employer-Provided Paid Leave means vacation leave, paid sick leave, paid personal leave, and any other employer-paid time off. Employer-provided paid leave does not include benefits under a short-term disability policy, long term disability policy, or a separate bank of time off solely for the purpose of paid family and medical leave.

Question 12: To qualify for reimbursement the Employer must pay Wage continuation or from a separate bank of time off solely for the purpose of paid family and medical leave to the covered Individual that is equal to or greater than the Weekly Benefit Amount. The Employer is not eligible for reimbursement for Employer-Provided Paid Leave paid to the Eligible Employee.

Question 13: If leave is caused by circumstances that entitle an individual to Workers' Compensation Benefits, the employee is not entitled to PFML.

If leave is caused by circumstances that entitle an individual to Unemployment Insurance Benefits, the employee is not entitled to intermittent or reduced schedule PFML.

Employer signs and dates, and then returns to the employee requesting CO PFML within three business days.

Be sure to complete the appropriate additional CO PFML form(s) based on the type of CO PFML leave being requested.

TO BE COMPLETED BY THE EMPLOYEE

Employee's name (first name, middle initial, last name)	Employee's date of birth (MM/DD/YYYY)
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PART A - EMPLOYEE INFORMATION (to be completed by the employee)

1. Employee's legal name (first name, middle initial, last name)	2. Other last names, if any, under which employee has worked				
3. Employee's mailing address Street	City		State	Zip Code	Country (if not USA)
4. Employee's Social Security Number or TIN	5. Employee's date of birth (MM/DD/YYYY)		6. Employee's primary telephone number ()		
7. Employee's preferred email address while on CO PFML (if available)			8. Employee's gender <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Not designated/Other		

9. Reason for CO PFML request:
Bonding: New child Adoption/Foster child
 Care for Family Member with a Serious Health Condition Safe Leave Military exigency
 Own Serious Health Condition due to pregnancy Own Serious Health Condition (other)

10. The family member is employee's: Child Spouse Sibling Parent Grandparent Grandchild
 Significant Personal Bond (affirm & provide detail in a. and b. below)

a. I hereby assert that a family-like relationship exists between _____
Your Name

 Name of person you have a family-like bond with

b. Describe how this relationship demonstrates a family relationship: _____

11. Will CO PFML be used for a Continuous period of time, Intermittently and/or on a Reduced Leave Schedule?

Continuous ____ / ____ / ____ ____ / ____ / ____ Dates are estimated
 start date (MM/DD/YYYY) end date (MM/DD/YYYY)

Intermittent (separate, non-consecutive time)
 Days/hours(s) requested: _____ Dates are estimated

Reduced Leave Schedule (consistent but reduced work schedule for multiple weeks)
 Days/hours(s) requested: _____ Dates are estimated
 (example: 2 days per week, or 4 hours per day, or every Monday)

Employment Information (to be completed by the employee)

12. Date employer was notified. If providing less than 30 day's advance notice to the employer, please explain:

13. Business name	14. Employee's date of hire (MM/DD/YYYY)	14a. Employee's last day of work (MM/DD/YYYY)
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15. Has your employment ended? If so, what was your termination date?

16. Employee's work location Street address

City	State	Zip code	Country (if not U.S.A.)
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17. Employer's telephone number for contact regarding this request.
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18. Are you receiving Workers' Compensation or Unemployment Insurance Benefits? Yes No

19. List income you will be receiving while on CO PFML, source of pay and amount.

20. Have you had a decrease in wages during the last 12 months? Yes No
 If yes, was it with your current Employer? Yes No

21. Have you taken any leave in the last 12 months? Yes No 22. If yes list dates and type of leave.

Disclosure statement: Information regarding CO PFML benefits received by the employee, such as payments received and types of leave, will be provided to the employer.

TO BE COMPLETED BY THE EMPLOYEE

Employee's name (first name, middle initial, last name)	Employee's date of birth (MM/DD/YYYY)
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Declaration and signature

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.

Employee's signature	Date signed (MM/DD/YYYY)
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I am submitting this form in advance (see instructions about pre-submitting). I understand the insurance carrier will contact me to advise how to submit the required missing information.

PART B - EMPLOYER INFORMATION (to be completed by the employer)

1. Business's full legal name and mailing address			
Mailing address			
City	State	Zip code	Country (if not U.S.A.)
2. Employer's FEIN			
3. Employer's EIN		4. Employer's contact name for questions related to CO PFML	
5. Employer's contact telephone number ()	6. Employer's contact email address		
7a. Employee's date of hire (MM/DD/YYYY)	7b. Employee's last day of work (MM/DD/YYYY)		
8a. Employee's Average Weekly Wage _____			
8b. Is employee subject to Social Security taxes? <input type="checkbox"/> Yes <input type="checkbox"/> No Medicare taxes? <input type="checkbox"/> Yes <input type="checkbox"/> No			
8c. Has employee met the annual limit to Social Security max. contribution? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A			
9. Check Days Normally Worked <input type="checkbox"/> Monday <input type="checkbox"/> Tuesday <input type="checkbox"/> Wednesday <input type="checkbox"/> Thursday <input type="checkbox"/> Friday <input type="checkbox"/> Saturday <input type="checkbox"/> Sunday Indicate Hours Normally Worked _____			
10. List the dates of any period a week or longer that the employee is not scheduled to work due to lapses in seasonal operations, school breaks, or other suspensions or cessations of business operations while on PFML leave, excluding holidays: (example: December 18 - January 1 and March 25 - March 31 or N/A if not applicable) _____			
11. Will wage continuation or internally sponsored paid family and medical leave be paid during the CO PFML leave period/dates? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide dates: _____			
12. If employee received or will receive wage continuation or internally sponsored paid family and medical leave while on CO PFML, will employer be requesting reimbursement? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide dates: _____			
13. Has the employee filed for Workers' Compensation Benefits or Unemployment Benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide benefit dates: _____			
14. CO PFML policy number			
CO PFML insurance carrier's name and mailing address Standard Insurance Company PO Box 3877, Portland, OR 97208 866-751-5174 Fax			
Declaration and signature			
<input type="checkbox"/> 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.			
Employer's authorized signature	Date signed (MM/DD/YYYY)		
Title			

If the employee is requesting Colorado Paid Family And Medical Leave (CO PFML) to bond with a newborn, an adopted child or a foster child, the employee must submit the *Bonding Certification* (Form CO PFML-2) with the *Request For Colorado Paid Family And Medical Leave* (Form CO PFML-1).

BONDING CERTIFICATION (to be completed by the employee)

The employee requesting CO PFML must complete all applicable requested information.

Send completed forms and supporting documentation to The Standard.

If this form is being submitted in advance (pre-submitting) and some information is unknown, the insurance carrier will contact the employee and explain how to provide the required additional information.

Question 1 & 2: If the form is submitted to the CO PFML insurance carrier prior to the birth of a child, this is considered pre-submitting. The employee is then required to provide the required documentation of the child's birth to the CO PFML insurance carrier. The CO PFML carrier will tell the employee how to provide the required additional documentation.

There may be instances where CO PFML can be taken before the adoption or foster care is finalized. For example, the employee may be required to appear in court or travel to another country as part of the adoption or foster care process. The employee should include documentation to show that the CO PFML is necessary to further the adoption or foster care.

Question 5: If dates are "Continuous", the employee must provide the start and end dates of the requested CO PFML. These dates should be the actual dates that the CO PFML will begin and end. If uncertain, estimate the start and end dates and indicate "Dates are estimated".

If dates are "Intermittent", enter the dates CO PFML will be taken. Please be as specific as possible. If the dates are unknown or estimated, indicate "Dates are estimated".

If the employee is working a consistent but reduced work schedule for multiple weeks, provide the days/hours of leave needed for CO PFML. If uncertain, estimate the frequency of leave and indicate "Dates are estimated".

Question 6: See chart below for documentation details. Unless specified, do not send the original documents.

Bonding Form/Certification	Description
Health Care Provider certification of pregnancy	An original letter obtained from the birth mother's Health Care Provider that certifies pregnancy. It should include the mother's name and the expected due date.
Health Care Provider certification of birth	An original letter obtained from the birth mother's Health Care Provider that includes the mother's name and child's date of birth.
Birth Certificate	A copy of the certificate issued by the city or county office in which the child is born.
Voluntary Acknowledgment of Paternity	A copy of the form that establishes legal fatherhood when the parents are unmarried. Completed by both mother and father.
Court Order of Paternity	Documentation of the order from the family court that names the father of a child. Establishes legal fatherhood when the parents are unmarried. Completed by both mother and father.
Marriage Certificate	A copy of the official statement issued by the town or city clerk from which the marriage certificate was issued.
Civil union/domestic partner's documentation	A copy of the certificate of civil union or domestic partnership.
Foster care placement letter	A copy of the letter of foster care placement issued by the county or city department of social services or authorized voluntary foster care agency.
Court documents of adoption	A copy of the court document finalizing adoption or documentation in furtherance or court order finalizing adoption.
Other documentation	Other documentation of parental relationship may be accepted if none of the others listed apply.

TO BE COMPLETED BY THE EMPLOYEE

Employee's legal name (first name, middle initial, last name)		Employee's date of birth (MM/DD/YYYY)		
Other last names, if any, under which employee has worked		Employee's Social Security Number or TIN		
Employee's mailing address Street				
City	State	Zip Code	Country (if not U.S.A.)	

BONDING CERTIFICATION (to be completed by the employee)

1. Child's date of birth (MM/DD/YYYY)	2. Child's gender <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Not designated/Other	3. Does child live with the employee requesting CO PFML? <input type="checkbox"/> Yes <input type="checkbox"/> No
4. Child is employee's: <input type="checkbox"/> Biological child <input type="checkbox"/> Stepchild <input type="checkbox"/> Foster child <input type="checkbox"/> Adopted child <input type="checkbox"/> Legal ward <input type="checkbox"/> <i>in loco parentis</i> child <input type="checkbox"/> Former minor child <i>in loco parentis</i> <input type="checkbox"/> Spouse/Domestic partner's child		
5. Will CO PFML be used for a Continuous period of time, Intermittently and/or on a Reduced Leave Schedule? <input type="checkbox"/> Continuous _____ / _____ / _____ _____ / _____ / _____ <input type="checkbox"/> Dates are estimated <small>start date (MM/DD/YYYY) end date (MM/DD/YYYY)</small> <input type="checkbox"/> Intermittent (separate, non-consecutive time) Days/hours(s) requested: _____ <input type="checkbox"/> Dates are estimated <input type="checkbox"/> Reduced Leave Schedule (consistent but reduced work schedule for multiple weeks) Days/hours(s) requested: _____ <input type="checkbox"/> Dates are estimated <small>(example: 2 days per week, or 4 hours per day, or every Monday)</small>		
6. Select one of the following and attach the document as required as evidence of the relationship. Parent of newborn child: Birth mother <input type="checkbox"/> Health Care Provider certification of pregnancy (include expected due date AND mother's name); OR <input type="checkbox"/> Health Care Provider certification of birth (include date of birth of child AND mother's name); OR <input type="checkbox"/> Child's birth certificate Other parent <input type="checkbox"/> Copy of birth certificate naming second parent; OR <input type="checkbox"/> Voluntary acknowledgment of paternity; OR <input type="checkbox"/> Court order of Paternity; OR <input type="checkbox"/> Birth mother documents (see above) PLUS one of the following: <input type="checkbox"/> Marriage certificate; OR <input type="checkbox"/> Certificate of civil union; OR <input type="checkbox"/> Evidence of domestic partnership <input type="checkbox"/> OR; Other documentation of parental relationship Foster parent <input type="checkbox"/> Letter of foster care placement or anticipated placement issued by county or city department of Social Services or authorized voluntary foster care agency Adoptive parent <input type="checkbox"/> Court document finalizing adoption <input type="checkbox"/> Documentation in furtherance of adoption		

7. Date of foster care or adoption placement, if applicable (MM/DD/YYYY)

Declaration and signature

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.

Employee's signature

Date signed (MM/DD/YYYY)