



**To Use Massachusetts Paid Family And Medical Leave For:  
Your own serious health condition**

**Complete Form MA PFML-1**

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

**Complete Form MA PFML-6**

- Complete MA PFML-6 and give to health care provider
- Health care provider keeps MA PFML-6

**Complete Form MA PFML-7**

- Complete "Employee" information at the top of MA PFML-7
- Provide MA PFML-7 to your healthcare provider
- Health care provider completes MA PFML-7 and returns to you

**Send forms and documents**

- Send completed forms and supporting documentation to The Standard
- The Standard accepts or denies claim within 14 days

**Please keep a copy of all pages for your records.**

- To request Massachusetts Paid Family And Medical Leave (MA PFML), the employee requesting MA PFML must complete Part A of the *Request For Massachusetts Paid Family And Medical Leave* (Form MA 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 Massachusetts Paid Family And Medical Leave* (Form MA 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 Massachusetts Paid Family And Medical Leave* (Form MA 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 MA PFML must complete all required information.*

**Massachusetts Paid Family And Medical Leave (MA PFML) Request (to be completed by the employee)**

**Question 10: Family member** means the spouse, domestic partner, child, parent or parent of a spouse or domestic partner of the employee; a person who stood in *loco parentis* to the employee when the employee was a minor child; or a grandchild, grandparent or sibling of the employee.  
**Child** means a biological, adopted or foster child, a stepchild or legal ward, a child to whom the employee stands in *loco parentis*.  
**Grandchild** means a child of the employee's child.  
**Grandparent** means a parent of the employee's parent.  
**Parent** means the biological, adoptive, step-brother or step-sister of the employee.  
**Spouse** means a husband or wife or domestic partner of an employee.

**Question 11:** If dates are "Continuous", the employee must provide the start and end dates of the requested MA PFML. These dates should be the actual dates that the MA PFML will begin and end. If uncertain, estimate the start and end dates and indicate "Dates are estimated". If dates are "Periodic", enter the dates MA PFML will be taken. Please be as specific as possible. If the dates are unknown or estimated, indicate "Dates are estimated".

If dates are estimated, The Standard may require you to submit a request for payment after the MA PFML day is taken. Payment for approved claims will be due as soon as possible but in no event more than 14 days from the date of the completed request.

**Question 12:** Date employer was notified. If the employee is submitting the MA PFML request to their employer with less than 30 days' advance notice from the start date of the MA 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 18:** List all other income you will be receiving while on MA PFML. Include the type/name of income and how much. Example PTO from employer for \$500.00 a week.

**If you are pre-submitting form:** Indicate if the employee is pre-submitting their MA PFML request. Pre-submitting is defined as submitting the application in advance of an upcoming qualifying event, with certain required information missing due to the information being unknown at the time of the submitting. If pre-submitting is permitted by The Standard, the missing information must be supplied as soon as it is known. Benefits cannot be determined until all of the required information is provided.

The Standard will provide the employee a notice within five days which 1) states the claim is pending; 2) identifies what information is missing; 3) instructs how to submit the missing information. **Once all information is supplied, The Standard has 14 days to pay or deny the claim.**

If The Standard does not permit pre-submitting, The Standard must return the Request for Massachusetts Paid Family And Medical Leave within five days to the employee with an explanation that the claim should be re-submitted when all information is available.

**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 MA 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.** You can call the state or check through the employer portal for this information.

“Wage” or “wages” means: For the purpose of payment of benefits, the remuneration paid by one or more employers to an employee for employment during the employee’s qualifying period.

Average Weekly Wage will be based on the weekly Wages in effect with the Employer on the day immediately preceding the date Family or Medical Leave under the Group Policy begins. For former Employees, the Average Weekly Wage will be based on Wages that were in effect on the last day the former Employee was in the employment of the Employer. 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, but not more than 40 hours. 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), but not more than 40 hours. If a Covered Individual has multiple Employers, the Average Weekly Wage will be calculated for each employer or Covered Business Entity separately.

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

**Be sure to complete the appropriate additional MA PFML form(s) based on the type of MA 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 MA PFML (if available)		8. Employee's gender <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Not designated/Other		
9. Reason for MA PFML request: <input type="checkbox"/> Bond with child <input type="checkbox"/> Care for family member <input type="checkbox"/> Military qualifying event <input type="checkbox"/> Own serious health condition <input type="checkbox"/> Care of a family member who is a service member				
10. The family member is employee's: <input type="checkbox"/> Child <input type="checkbox"/> Spouse or registered domestic partner <input type="checkbox"/> Sibling <input type="checkbox"/> Parents and legal guardians (or spouse's parent) <input type="checkbox"/> Grandparent <input type="checkbox"/> Grandchild				
11. Will MA PFML be for a continuous period of time and/or periodic? <input type="checkbox"/> Continuous _____ / _____ / _____ MA PFML start date (MM/DD/YYYY) _____ / _____ / _____ MA PFML end date (MM/DD/YYYY) <input type="checkbox"/> Dates are estimated				
Identify dates periodic MA PFML will be taken: <input type="checkbox"/> Periodic _____ <input type="checkbox"/> Dates are estimated				
If providing less than 30 days advanced notice to the employer, please explain: _____				

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

**Employment Information (to be completed by the employee)**

13. Business name	14. Employee's date of hire (MM/DD/YYYY)	14a. Employee's last day of work (MM/DD/YYYY)		
15. Employee's work location Street address	City	State	Zip code	Country (if not U.S.A.)
16. Employer's telephone number for contact regarding this request. ( )	17. Is employee currently receiving Workers' Compensation Benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No			
18. List pay you will be receiving while on MA PFML, source of pay and amount.				
19. Have you taken any leave in the last 52 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No	20. If yes list dates and type of leave.			

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

**Declaration and signature**

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.  
 I am hereby making a request for paid family and medical leave benefits under the Massachusetts State Paid Family And Medical Leave Law. My signature affirms that the information I am providing is true and accurate to the best of my knowledge and belief.

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.

**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 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 MA PFML	
5. Employer's contact telephone number (        )	6. Employer's contact email address		
7. Employee's date of hire (MM/DD/YYYY)	7a. Employee's last day of work (MM/DD/YYYY)		
8. Employee's Average Weekly Wage			
9. Employee's Typical Work Week Hours			
10a. 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			
10b. Is employee hourly or salaried? <input type="checkbox"/> Hourly <input type="checkbox"/> Salaried			
11. List the last date the employee will receive pay, for example the last date through which sick leave benefits, if any, will be paid.			
12a. What type of paid benefits will the employee receive while on MA PFML? Include the last date through which any compensation will be paid.			
12b. If, while on fully-insured MA PFML, the employee will receive wages in the form of sick leave, PTO, vacation or an extended illness leave bank that is at least equal to the benefit under the Group Policy, will the employer be requesting reimbursement? <input type="checkbox"/> Yes <input type="checkbox"/> No			
13. Is the employee taking federal Family Medical Leave Act (FMLA)? <input type="checkbox"/> Yes <input type="checkbox"/> No	14. MA PFML policy number		
MA PFML insurance carrier's name and mailing address <b>Standard Insurance Company</b> <b>PO Box 3877</b> <b>Portland, OR 97208</b> <b>866-751-5174 Fax</b>			
<b>Declaration and signature</b> <input type="checkbox"/> I affirm the employee meets the eligibility for Massachusetts Paid Family And Medical Leave. I am the person authorized to sign as the employer of the employee requesting MA PFML. My signature affirms that to the best of my knowledge and belief, the information I have provided is true and accurate.			
Employer's authorized signature	Date signed (MM/DD/YYYY)		
Title			

**Notice to the Employee About Use of this Authorization**

As you may know, the Massachusetts Paid Family And Medical Leave Act (MA PFML) permits an employer or leave administrator to contact an employee’s health care provider, with the employee’s permission, for the purpose of clarifying or authenticating an otherwise complete and sufficient MA PFML medical certification. For MA PFML purposes, “clarifying” means to understand the meaning of a response or to understand the handwriting and “authenticating” means to provide the health care provider with a copy of the medical certification to verify the information on the form.

To help streamline MA PFML administration and minimize the need to contact you during leave, we have developed the attached MA PFML Authorization. By signing the Authorization, you provide Standard Insurance Company (The Standard) permission to contact your health care provider to clarify and/or authenticate medical certifications under MA PFML. You are not required to complete and sign the Authorization for The Standard to process your request for MA PFML leave. However, completing and signing the Authorization now may shorten the time it takes to clarify or authenticate a medical certification later.

If you decide to sign the Authorization now, you may still revoke it at any time. In addition, before contacting your health care provider to clarify and/or authenticate a medical certification, we will notify you in writing and explain the: (1) specific reason(s) we want to clarify and/or authenticate the certification; (2) information required to clarify and/or authenticate the certification; and (3) time period within which you and/or your health care provider must provide the information needed to clarify and/or authenticate the certification.

If you would like us to authorize now any future MA PFML clarification or authentication, please review the Authorization carefully and complete, sign and return the Authorization to the address above.

I authorize any physician, medical practitioner or healthcare provider (referred to as “health provider”) who has completed a medical certification form for \_\_\_\_\_ (patient name) to discuss with or disclose to STANDARD INSURANCE COMPANY, my health information needed to clarify statements or information provided by health provider on a medical certification form which had been completed by health provider.

- I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct my health provider to release and disclose without restriction information reasonably necessary to clarify or authenticate information provided on a previously completed medical certification form.
- I have the right to refuse to sign this authorization and a right to revoke this authorization at any time by sending a written statement to The Standard, 1100 SW Sixth Avenue, Portland OR 97204, except to the extent the authorization has been relied upon to clarify or authenticate information. A revocation of the authorization, or the failure to sign the authorization, may impair The Standard’s ability to evaluate or process the request for leave of absence.
- I understand that in the course of conducting its business The Standard may disclose information to my employer regarding my leave of absence request and status, including a completed return to work authorization form.
- I understand that the information disclosed to The Standard pursuant to this authorization may be subject to redisclosure with my authorization or as otherwise permitted or required by federal or state law. Information retained and disclosed by The Standard may not be protected under the Health Insurance Portability and Accountability Act [HIPAA].
- I understand and agree that this authorization is valid for 12 months from the date signed below.
- A photocopy or facsimile of this authorization is as valid as the original and will be provided to me upon request.

Name (please print)

Signature of Claimant/Representative

Date

*If signature is provided by legal representative (e.g., Attorney in Fact, guardian or conservator), please attach documentation of legal status.*

Employee's Name	Date of Birth
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**INSTRUCTIONS for HEALTH CARE PROVIDERS**

This form is used to certify a serious health condition in order to qualify for Massachusetts Paid Family and Medical Leave (MA PFML). Qualifying serious health conditions and authorized healthcare providers are described below. Answer each question to the best of your medical knowledge, based on your examination of the patient.

**SERIOUS HEALTH CONDITION**

A "serious health condition", is defined as an illness, injury, impairment or physical or mental condition that involves: (a) inpatient care in a hospital, hospice or residential medical facility; (b) continuing treatment by a health care provider; or (c) a Substance Use Disorder (Note: an absence because of an Employee's use of a substance, rather than for treatment, is not a Serious Health Condition).

**Inpatient care:** Inpatient care in a hospital, hospice, or residential medical care facility, including any period of incapacity; or

**Continuing Treatment by a Health Care Provider includes any one or more of the following:**

**Incapacity and treatment.** A period of incapacity of more than three consecutive, full calendar days, and any subsequent treatment or period of incapacity relating to the same condition, that also involves:

- Treatment two or more times, within 30 calendar days of the first day of incapacity, unless extenuating circumstances exist, by a health care provider, by a nurse under direct supervision of a health care provider, or by a provider of health care services (e.g., physical therapist) under orders of, or on referral by, a health care provider; or
- Treatment by a health care provider on at least one occasion, which results in a regimen of continuing treatment under the supervision of the health care provider. Treatment includes examination to determine if there is a serious health condition.
- Treatment does not include routine physical examinations, eye examinations, or dental examinations. A regimen of continuing treatment includes a course of prescription medication or therapy requiring specialized equipment to resolve or alleviate the health condition.
- The requirement for treatment by a health care provider means an in-person visit to a health care provider. The first (or only) in-person treatment visit must take place within seven calendar days of the first day of incapacity.
- Whether additional treatment visits or a regimen of continuing treatment is necessary within the 30-day period shall be determined by the health care provider.
- The term extenuating circumstances means circumstances beyond the employee's control that prevent the follow-up visit from occurring as planned by the health care provider. Whether a given set of circumstances are extenuating depends on the facts. For example, extenuating circumstances exist if a health care provider determines that a second in-person visit is needed within the 30-day period, but the health care provider does not have any available appointments during that time period.

**Pregnancy or Prenatal Care.** Any period of incapacity due to pregnancy, or for prenatal care.

**Chronic Conditions.** Any period of incapacity or treatment for such incapacity due to a chronic serious health condition. A chronic serious health condition is one which:

- Requires periodic visits (defined as at least twice a year) for treatment by a health care provider, or by a nurse under direct supervision of a health care provider;
- Continues over an extended period of time (including recurring episodes of a single underlying condition); and
- May cause episodic rather than a continuing period of incapacity (e.g., asthma, diabetes, epilepsy, etc.).

**Permanent or Long-term Conditions.** A period of incapacity which is permanent or long-term due to a condition for which treatment may not be effective. The Covered Individual or the Covered Individual's family member must be under the continuing supervision of, but need not be receiving active treatment by, a health care provider. Examples include Alzheimer's, a severe stroke, or the terminal stages of a disease.

**Conditions Requiring Multiple Treatments.** Any period of absence to receive multiple treatments (including any period of recovery therefrom) by a health care provider or by a provider of health care services under orders of, or on referral by, a health care provider, for:

- Restorative surgery after an accident or other injury; or
- A condition that would likely result in a period of incapacity of more than three consecutive, full calendar days in the absence of medical intervention or treatment, such as cancer (chemotherapy, radiation, etc.), severe arthritis (physical therapy), or kidney disease (dialysis).
- Absences attributable to incapacity under Continuing Treatment by a Health Care Provider (b) or (c) qualify for leave even though the employee, Covered Individual or the covered family member does not receive treatment from a health care provider during the absence, and even if the absence does not last more than three consecutive, full calendar days.
- Cosmetic treatments or substance abuse disorders are not serious health conditions unless inpatient hospital care is required or unless complications develop.

**Substance Use Disorder** means a substance use disorder of a Covered Individual or Family Member treated by a Health Care Provider, or a provider of health care services on referral by a Health Care Provider, or by a program licensed or approved by the Massachusetts Department of Public Health.

#### **HEALTHCARE PROVIDERS**

**Health Care Provider**, an individual licensed by the State in which the individual practices to practice medicine, surgery, dentistry, chiropractic, podiatry, midwifery or osteopathy, and including the following:

- Podiatrists, dentists, clinical psychologists, optometrists, and chiropractors (limited to treatment consisting of manual manipulation of the spine to correct a subluxation as demonstrated by X-ray to exist) authorized to practice in by a State and performing within the scope of their practice as defined under that State's law;
- Nurse practitioners, nurse-midwives, clinical social workers and physician assistants who are authorized to practice under State law and who are performing within the scope of their practice as defined under State law;
- Christian Science Practitioners listed with the First Church of Christ, Scientist in Boston, Massachusetts.
- A health care provider listed above who practices in a country other than the United States, who is authorized to practice in accordance with the law of that country, and who is performing within the scope of the person's practice as defined under such law.

NOTE: The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic Information" as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.



Employee's Name	Date of Birth
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**PART A: MEDICAL FACTS**

1. Diagnosis: \_\_\_\_\_ Primary ICD Code (optional): \_\_\_\_\_  
 Approximate date condition commenced: \_\_\_\_\_ Probable duration of condition: \_\_\_\_\_  
 Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility?  Yes  No  
 If so, dates of admission: \_\_\_\_\_  
 \_\_\_\_\_  
 Date(s) you treated the patient for condition: \_\_\_\_\_  
 \_\_\_\_\_  
 Will the patient need to have treatment visits at least twice per year due to the condition?  Yes  No  
 Was the patient referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)?  Yes  No  
 If so, state the nature of such treatments and expected duration of treatment: \_\_\_\_\_  
 \_\_\_\_\_
2. Is the medical condition pregnancy?  Yes  No If so, expected/actual delivery date: \_\_\_\_\_
3. Complications with pregnancy or delivery?  Yes  No If yes please explain: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_
4. Describe other relevant medical facts, if any, related to the condition for which the employee seeks leave (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment):  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**PART B: AMOUNT OF LEAVE NEEDED**

5. Will the employee be incapacitated for a single continuous period of time due to his/her medical condition, including any time for treatment and recovery?  Yes  No  
 If so, estimate the beginning and ending dates for the period of incapacity: \_\_\_\_\_
6. Will the employee need to attend follow-up treatment appointments or work part-time or on a reduced schedule because of the employee's medical condition?  Yes  No  
 If so, are the treatments or the reduced number of hours of work medically necessary?  Yes  No  
 Estimate treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including any recovery period: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 Estimate the part-time or reduced work schedule the employee needs, if any:  
 \_\_\_\_\_ hour(s) per day; \_\_\_\_\_ days per week from \_\_\_\_\_ through \_\_\_\_\_

Employee's Name	Date of Birth
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7. Will the condition cause episodic flare-ups periodically preventing the employee from performing his/her job functions?  Yes  No  
 Is it medically necessary for the employee to be absent from work during the flare-ups?  Yes  No

If so, explain: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Based upon the patient's medical history and your knowledge of the medical condition, estimate the frequency of flare-ups and the duration of related incapacity that the patient may have over the next 6 months (e.g., 1 episode every 3 months lasting 1-2 days):

Frequency: \_\_\_\_\_ times per \_\_\_\_\_ week(s) \_\_\_\_\_ month(s)  
 Duration: \_\_\_\_\_ hours or \_\_\_\_\_ day(s) per episode

ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER.

Health Care Provider's Name

Address	City	State	ZIP
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Phone No.	Fax No.
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Specialty/Type of Practice	License No.
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I declare under penalty of perjury that the information provided in this form is true and correct, that the patient's condition meets the definition of "serious health condition" [458 CMR 2.02], and that I am a healthcare provider authorized to certify their condition [458 CMR 2.02].

Signature of Health Care Provider	Date
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