TheStandard®

Reset

Standard Insurance Company
866.756.8116 Tel 866.751.5174 Fax
PO Box 3877 Portland OR 97208

# Applying For Washington Paid Family And Medical Leave (WA PFML)

## To Use Washington Paid Family And Medical Leave To:
## Assist family members due to another family member's active military duty or impending active duty abroad

**Complete Form WA PFML-1**
- ☐ Complete WA PFML-1, Part A
- ☐ Provide WA PFML-1 to employer
- ☐ Employer completes WA PFML-1, Part B and returns to you within 3 days

**Complete Form WA PFML-5**
- ☐ Complete WA PFML-5 and collect supporting documentation

**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.**

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# Request For Washington Paid Family And Medical Leave (Form WA PFML-1) Instructions

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

### Washington Paid Family And Medical Leave (WA PFML) Request (to be completed by the employee)

**Question 10: Family member** means a child, grandchild, grandparent, parent, sibling, or spouse of an employee.
**Child** includes a biological, adopted, or foster child, a stepchild, child's spouse, or a child to whom the employee stands in loco parentis, is a legal guardian, or is a de facto parent, regardless of age or dependency status.
**Grandchild** means a child of the employee's child.
**Grandparent** means a parent of the employee's parent.
**Parent** means the biological, adoptive, de facto, or foster parent, stepparent, or legal guardian of an employee or the employee's spouse, or an individual who stood in loco parentis to an employee when the employee was a child.
**Spouse** means a husband or wife or state registered domestic partner.

**Question 11:** If dates are "Continuous", the employee must provide the start and end dates of the requested WA PFML. These dates should be the actual dates that the WA 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 WA 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 WA 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 WA PFML request to their employer with less than 30 days' advance notice from the start date of the WA 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 WA 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 WA 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 Washington 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.**

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

***The employer of the employee requesting WA 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.

"Employee's average weekly wage" means the quotient derived by dividing the employee's total wages during the two quarters of the employee's qualifying period in which total wages were highest by twenty-six. If the result is not a multiple of one dollar, we will round the result to the next lower multiple of one dollar.

**Question 9.** You can call the state or check through the employer portal for this information. The state will have hours from all employers the employee has worked. Typical workweek hours means: (a) For an hourly employee, the average number of hours worked per week by an employee since the beginning of the qualifying period; and (b) Forty hours for a salaried employee, regardless of the number of hours the salaried employee typically works.

For salaried employees, the number of hours worked in a week are assumed to be forty, regardless of how many hours are actually worked. Typical workweek hours are determined by multiplying the number of weeks in the qualifying period the employee held the salaried position by forty, adding any other hours that were not salaried, if any, and then dividing that amount by fifty-two. For all other employees, typical workweek hours are determined by dividing the sum of all hours reported in the qualifying period by fifty-two.

Qualifying period means the first four of the last five completed calendar quarters or, if eligibility is not established, the last four completed calendar quarters immediately preceding the application for leave.

**Affirmation employee is eligible for WA PFML:** To be eligible for any family and medical leave, an employee must be in employment in the state of WA for eight hundred twenty hours during the qualifying period, by an employer with a voluntary plan or an employer utilizing the state family and medical leave plan. An employee qualifies for benefits under an employer's voluntary plan after the employee works at least three hundred forty hours for the current employer, unless this requirement is waived by the employer.

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

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

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# Request For Washington Paid Family And Medical Leave (Form WA PFML-1)

**TO BE COMPLETED BY THE EMPLOYEE**

| Employee's name (first name, middle initial, last name) | Employee's date of birth (MM/DD/YYYY) |
|---|---|
| | |

## 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 WA PFML (if available) | 8. Employee's gender ☐ Male ☐ Female ☐ Not designated/Other |
|---|---|
| | |

9. Reason for WA PFML request: ☐ Bond with child ☐ Care for family member ☐ Military qualifying event ☐ Own serious health condition

10. The family member is employee's: ☐ Child (biological, adopted, foster, stepchild or child's spouse) ☐ Spouse or registered domestic partner ☐ Sibling ☐ Parents and legal guardians (or spouse's parent) ☐ Grandparent (or spouse's grandparent) ☐ Grandchild

11. Will WA PFML be for a continuous period of time and/or periodic?

☐ Continuous _____ / _____ / _____ _____ / _____ / _____ ☐ Dates are estimated
WA PFML start date (MM/DD/YYYY) WA PFML end date (MM/DD/YYYY)

Identify dates periodic WA PFML will be taken:

☐ Periodic _____ ☐ Dates are estimated

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) |
|---|---|
| | |

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 Lost Wage Benefits? ☐ Yes ☐ No |
|---|---|
| | |

18. List pay you will be receiving while on WA PFML, source of pay and amount.

| 19. Have you taken any leave in the last 52 weeks? ☐ Yes ☐ No | 20. If yes list dates and type of leave. |
|---|---|
| | |

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

**Declaration and signature**

An individual is disqualified for benefits for any week he or she has knowingly and willfully made a false statement or representation involving a material fact or knowingly and willfully failed to report a material fact and, as a result, has obtained or attempted to obtain any benefits under the Washington Paid Family And Medical Leave Law.

I am hereby making a request for paid family and medical leave benefits under the Washington 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) |
|---|---|
| | |

☐ 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.

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**Request For**
**Washington Paid Family And Medical Leave**
**(Form WA PFML-1)**

**TO BE COMPLETED BY THE EMPLOYEE**

| Employee's name (first name, middle initial, last name) | Employee's date of birth (MM/DD/YYYY) |
|---|---|
| | |

## 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. UBI Number | 4. Employer's contact name for questions related to WA PFML | | |
| | | | |
| 5. Employer's contact telephone number ( ) | 6. Employer's contact email address | 7. Employee's date of hire (MM/DD/YYY) | |
| | | | |
| 8. Employee's Average Weekly Wage as provided by Washington state for WA PFML | | | |
| 9. Employee's Typical Work Week Hours as provided by Washington state for WA PFML | | | |
| 10. Check Days Normally Worked ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday ☐ Sunday | | | |
| 10a. Is employee hourly or salaried? ☐ Hourly ☐ Salaried | | | |
| 11a. When reporting employee wages to the state of Washington, do you include sick leave, PTO, or any other income as wages? ☐ Yes ☐ No | | | |
| 11b. If yes which ones? | | | |
| 12. What type of paid benefits will the employee receive while on WA PFML? | | | |
| 13. Is the employee taking federal Family Medical Leave Act (FMLA) concurrently with WA PFML? ☐ Yes ☐ No | 14. WA PFML policy number | | |
| WA PFML insurance carrier's name and mailing address<br>**Standard Insurance Company**<br>**PO Box 3877**<br>**Portland, OR 97208**<br>**866-751-5174 Fax** | | | |

**Declaration and signature**

☐ I affirm the employee meets the eligibility for Washington Paid Family And Medical Leave, unless I have waived this requirement.

I am the person authorized to sign as the employer of the employee requesting WA 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 | |
| | |

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# Washington Paid Family And Medical Leave Certification for Military Exigency (Form WA PFML-5)

| Employee's Name | Name of covered military member on active duty or call to active duty status |
|---|---|
| Relationship of covered military member to employee | Dates of covered military member's active duty service |

Please check one of the following:

☐ A copy of the covered military member's active duty orders is attached.
☐ Other documentation from the military certifying that the covered military member is on active duty (or has been notified of an impending call to active duty) in support of a contingency operation is attached.
☐ I have previously provided my employer with sufficient documentation confirming the covered military member's active duty or call to active duty status in support of a contingency operation.

**Description of qualifying exigency** *(On page 2 of this form is the description of a "qualifying exigency." Does the need for leave qualify under any of the categories described? If so, please check the applicable category.)*

☐ (1) ☐ (2) ☐ (3) ☐ (4) ☐ (5) ☐ (6) ☐ (7) ☐ (8) ☐ (9)

Describe the reason you are requesting leave due to a qualifying exigency (including the specific reason you are requesting leave):

Please attach any available written documentation which supports the need for leave; such documentation may include a copy of a meeting announcement for informational briefings sponsored by the military, a document confirming an appointment with a counselor or school official, or a copy of a bill for services for the handling of legal or financial affairs.

Available written documentation is attached. ☐ Yes ☐ None Available

Approximate date exigency commenced or will commence _____

Probable duration of exigency _____

Will you need to be absent from work for a single continuous period of time due to the qualifying exigency? ☐ Yes ☐ No

If so, estimate the beginning and ending dates for the period of absence _____

Will you need to be absent from work periodically to address this qualifying exigency? ☐ Yes ☐ No

Estimate the frequency and duration of each period of absence due to the qualifying exigency (e.g. 3x per month lasting 4 hours):

Frequency: _____ times per _____ week(s) _____ month(s)

Duration: _____ hour(s) or _____ day(s) per event

## Leave to Meet with a Third Party

Please complete this section if leave is requested to meet with a third party (such as to arrange for childcare, to attend counseling, to attend meetings with school or childcare providers, to make financial or legal arrangements, make arrangements for care of parent, to act as the covered military member's representative before a federal, state or local agency for purposes of obtaining, arranging or appealing military service benefits, or to attend any event sponsored by the military or military service organizations). This information may be used by your employer to verify that the information contained on this form is accurate.

| Name of Individual or Entity with whom you are meeting | | Title |
|---|---|---|
| Organization | | |
| Address | | |
| Phone No. | Fax No. | Email |
| Briefly describe the purpose of the meeting | | |

**Declaration and signature**

An individual is disqualified for benefits for any week he or she has knowingly and willfully made a false statement or representation involving a material fact or knowingly and willfully failed to report a material fact and, as a result, has obtained or attempted to obtain any benefits under the Washington 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.

| Signature of Employee | Date |
|---|---|

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## WA PFML Description of a Qualifying Exigency

Eligible employees may take Washington Paid Family And Medical Leave (WA PFML) while the employee's spouse, child, grandchild, grandparent, parent or sibling (i.e. the "covered military member") is on active duty or call to active duty status for one or more of the following qualifying exigencies:

1. **Short-Notice Deployment**

   Any issue that arises from the fact that a covered military member is notified of an impending call or order to active duty in support of a contingency operation seven or less calendar days prior to the date of deployment.

2. **Military Events and Related Activities**

   Leave to attend any official ceremony, program or event sponsored by the military that is related to active duty or call to active duty status of a covered military member; or leave to attend family support or assistance programs and informal briefings sponsored or promoted by the military, military service organizations, or the American Red Cross that are related to the active duty or call to active duty status of a covered military member.

3. **Childcare and School Activities**

   When necessary due to circumstances arising from the active duty or call to active duty status of a covered military member – leave to arrange for alternative childcare; to enroll in or transfer the military service member's child to a new school or daycare facility; to attend meetings with staff at a school or daycare facility concerning the covered service member's child; or to provide childcare on an immediate need basis.

4. **Arrangements for Care of Parent**

   Certain activities arising from the military member's covered active duty related to care of the military member's parent who is incapable of self-care, such as arranging for alternative care, providing care on a non-routine, urgent, immediate need basis, admitting or transferring a parent to a new care facility, and attending certain meetings with staff at a care facility, such as meetings with hospice or social service providers.

5. **Financial and Legal Arrangements**

   To make or update financial or legal arrangements to address the covered military member's absence, such as preparing and executing powers of attorney, transferring bank account signature authority, preparing a living will or trust, or enrolling in Defense Enrollment Eligibility System (DEERS).

6. **Counseling**

   To attend counseling provided by someone other than a health care provider for oneself, for the covered military member. Or for the child of the covered military service member provided that the need for counseling arises from the active duty or call to active duty status of a covered military member.

7. **Rest and Recuperation**

   To spend time with a covered military member who is on short-term, temporary, rest and recuperation leave during the period of deployment.

8. **Post-Deployment Activities**

   To attend any official ceremony or program sponsored by the military for a period of 90 days following the termination of the covered military member's active duty status (i.e. arrival ceremonies or reintegration events); or to address issues that arise from the death of a covered military member while on active duty status.

9. **Additional Activities**

   Other events that arise out of the covered military member's active duty or call to active duty status provided the employer and employee agree that such leave shall qualify as an exigency, and agree to both the timing and duration of such leave.

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