TheStandard®

Reset

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

Applying For Paid Family And Medical Leave (PFML)

To Use Paid Family And Medical Leave To:
Care for a family member with a serious health condition

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

Complete Form PFML-3
- ☐ Care recipient completes PFML-3 and provides to Health Care Provider
- ☐ Care recipient's Health Care Provider keeps PFML-3

Complete Form PFML-4
- ☐ Complete "Employee" information at the top of PFML-4
- ☐ Provide PFML-4 to care recipient's Health Care Provider
- ☐ Care recipient's Health Care Provider completes PFML-4 and returns to you

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.

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Request For Connecticut Paid Family And Medical Leave (Form CT PFML-1) Instructions

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

Connecticut Paid Family And Medical Leave (CT PFML) Request (to be completed by the employee)

Question 10: Family member means an employee's spouse, sibling, son or daughter, grandparent, grandchild, parent (includes parent-in-law), or an individual related to the employee by blood or affinity whose close association the employee shows to be the equivalent of those family relationship.
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, parent-in-law, adoptive, step-brother or step-sister of the employee.
Spouse means a husband or wife or domestic partner of an employee.
Family Member Equivalent: an individual related to the employee by blood or affinity whose close association the employee shows to be the equivalent of those family relationship.

Question 11: If dates are "Continuous", the employee must provide the start and end dates of the requested CT PFML. These dates should be the actual dates that the CT 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 CT 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 CT PFML day is taken. Payment for approved claims will be due 15 calendar days from the date of the claim decision.

Question 12: Date employer was notified. If the employee is submitting the CT PFML request to their employer with less than 30 days' advance notice from the start date of the CT 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 CT 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 CT 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. **Payment for approved claims will be due 15 calendar days from the date of the claim decision.**

If The Standard does not permit pre-submitting, The Standard must return the Request for Connecticut 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 CT 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.

"Wage" or "wages": For the purpose of payment of benefits, means a Covered Employee's remuneration from the Employer for employment and dismissal payments.

Weekly Wages: means an amount equal to one twenty sixth, rounded to the next lower dollar, of a Covered Employee's Total Wages, as defined in subsection (b) of Section 31-222 of the general statutes, or self-employment income, as defined in 26 USC 1402(b), as amended from time to time, earned during the two quarters of the Covered Employee's base period in which such earnings were highest.

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

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

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Request For Connecticut Paid Family And Medical Leave (Form CT 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 CT PFML (if available)	8. Employee's gender ☐ Male ☐ Female ☐ Not designated/Other

9. Reason for CT PFML request:
☐ Bond with child ☐ Adoption/Foster child ☐ Care for family member ☐ Employee Impacted by Family Violence
☐ Military qualifying event ☐ Military Caregiver: Care of a family member injured in the line of duty
☐ Own serious health condition due to Covered Employee serving as a Bone Marrow Donor
☐ Own serious health condition due to Covered Employee serving as an Organ Donor
☐ Own serious health condition due to pregnancy ☐ Own serious health condition (other)

10. The family member is employee's: ☐ Child ☐ Spouse or registered domestic partner ☐ Family Member Equivalent
☐ Sibling ☐ Parents and legal guardians (or spouse's parent) ☐ Grandparent ☐ Grandchild

11. Will CT PFML be for a continuous period of time and/or periodic?
☐ Continuous _____ / _____ / _____ _____ / _____ / _____ ☐ Dates are estimated
CT PFML start date (MM/DD/YYYY) CT PFML end date (MM/DD/YYYY)

Identify dates periodic CT 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)	14a. Employee's last day of work (MM/DD/YYYY)

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.)

17. Employer's telephone number for contact regarding this request. ( )	18. Is employee currently receiving Workers' Compensation Benefits? ☐ Yes ☐ No

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

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

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

Declaration and signature

Under penalties of perjury, I declare that to the best of my knowledge and belief, the information contained herein is true, correct, and complete. Any false statements or other failure to provide truthful, accurate and complete information may result in monetary and other penalties as well as the possibility of criminal prosecution.

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 Connecticut Paid Family And Medical Leave (Form CT 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. Employer's EIN	4. Employer's contact name for questions related to CT 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 Weekly Wages			
9. Employee's Typical Work Week Hours			

10a. Check Days Normally Worked ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday ☐ Sunday

10b. Is employee hourly or salaried? ☐ Hourly ☐ 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.

12. Will any full days of accrued paid time* be used in place of PFML benefits? ☐ Yes ☐ No
If so, please provide dates where full days of accrued paid time is being used. _____
**Accrued paid time could be sick leave, annual leave, vacation leave, personal leave, compensatory leave or paid time off.*
Use of full days of accrued paid time, in place of PFML benefits, will not decrement the employee's PFML bank.

13a. What type of paid benefits will the employee receive while on CT PFML? Include the last date through which any compensation will be paid.

13b. Is the leave request a result of employee's injury on the job? ☐ Yes ☐ No
If yes, has the employee applied for Worker's Compensation payments/benefits? ☐ Yes ☐ No
If yes, has the employee received Worker's Compensation payments/benefits? ☐ Yes ☐ No
Amount of Weekly Payment/Benefit: $_____ Effective date of benefits: _____

14. CT PFML policy number

CT PFML insurance carrier's name and mailing address
Standard Insurance Company
PO Box 3877
Portland, OR 97208
866-751-5174 Fax

Declaration and signature

☐ I affirm the employee meets the eligibility for Connecticut Paid Family And Medical Leave.
Under penalties of perjury, I declare that to the best of my knowledge and belief, the information contained herein is true, correct, and complete. Any false statements or other failure to provide truthful, accurate, and complete information may result in monetary and other penalties as well as the possibility of criminal prosecution.

Employer's authorized signature	Date signed (MM/DD/YYYY)
Title	

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Paid Family And Medical Leave Release Of Personal Health Information For Family Member (Form PFML-3)

- If an employee is requesting Paid Family And Medical Leave (PFML) to care for a family member with a serious health condition, the family member or an authorized representative must complete a *Release Of Personal Health Information For Family Member* (Form PFML-3) and submit it to their Health Care Provider, along with a copy of the *Certification For Care Of Family Member* (Form PFML-4).
- The *Release Of Personal Health Information For Family Member* (Form PFML-3) enables the Health Care Provider to complete *Certification For Care Of Family Member* (Form PFML-4) and release it to the employee seeking PFML benefits.
- Before completing and signing, the family member must read the *Release Of Personal Health Information For Family Member* (Form PFML-3) in its entirety.
- The employee requesting PFML submits both the *Request For Paid Family And Medical Leave* (Form PFML-1) and the *Certification For Care Of Family Member* (Form PFML-4) to their employer's PFML insurance carrier, for PFML benefit determination.

NOTE: This form will be retained by the Health Care Provider. The employee should make a copy for their records before giving it to the Health Care Provider.

Family member or authorized representative signs and dates.

RELEASE OF PERSONAL HEALTH INFORMATION BY THE HEALTH CARE PROVIDER FOR A FAMILY MEMBER WITH A SERIOUS HEALTH CONDITION (to be completed by the family member or authorized representative and submitted to family member's Health Care Provider with Form PFML-4)

Employee enters their name, and family member's name and date of birth at the top of each page.

The PFML insurance carrier name requested at the top of the form is the same as the PFML insurance carrier identified in *Request For Paid Family And Medical Leave* (Form PFML-1) Part B line 13.

Family member or authorized representative must complete all applicable requested information.

If a family member is unable to fill out this form, an authorized representative must attach a copy of legal documentation, such as a health care proxy or power of attorney, permitting the representative to sign on behalf of the family member. The Health Care Provider will require this documentation of authorization unless the authorized representative is a parent signing on behalf of a minor child.

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Paid Family And Medical Leave
Release Of Personal Health Information
For Family Member
(Form PFML-3)

TO BE COMPLETED BY THE EMPLOYEE

Employee's legal name (first name, middle initial, last name)	
Family member's legal name	Family member's date of birth (MM/DD/YYYY))
Relationship of family member to employee	

RELEASE OF PERSONAL HEALTH INFORMATION BY THE HEALTH CARE PROVIDER FOR A FAMILY MEMBER WITH A SERIOUS HEALTH CONDITION (to be completed by the family member or authorized representative and submitted to family member's Health Care Provider with Form PFML-4)

I, _____ , authorize my Health Care Provider listed on this form to
Family member's legal name

release my personal health information to _____ and Standard Insurance Company.
Employee's legal name

Records Subject to Release: This form gives the Health Care Provider listed permission to include information from your health care records on the attached medical certification. This form gives your Health Care Provider permission to release only the information in your health care records that relate to your current condition, which is the subject of the employee's request for Paid Family And Medical Leave benefits.

Duration of Revocable Release: This authorization ends after one year, or when you revoke the release. You can cancel this release at any time. To cancel, send a letter to the Health Care Provider listed on this form.

This form does NOT allow your Health Care Provider to release the following types of information, unless you specifically permit such release. Put an "X" next to any information your health provider MAY release:

☐ HIV/AIDS related information ☐ Mental health information ☐ Alcohol/drug treatment ☐ Psychotherapy notes

Health Care Provider Information (to be completed by the family member 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 PFML benefits.

1. Health Care Provider's name			
2. Health Care Provider's mailing address			
City	State	Zip Code	Country (if not U.S.A.)
3. Health Care Provider's telephone number (provide area or country code) ( )			

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Paid Family And Medical Leave
Release Of Personal Health Information
For Family Member
(Form PFML-3)

TO BE COMPLETED BY THE EMPLOYEE

Employee's legal name (first legal name, middle initial, last name)	
Family member's legal name (first name, middle initial, last name)	Family member's date of birth (MM/DD/YYYY)

RELEASE OF PERSONAL HEALTH INFORMATION BY THE HEALTH CARE PROVIDER FOR A FAMILY MEMBER WITH A SERIOUS HEALTH CONDITION (to be completed by the family member or authorized representative and submitted to family member's Health Care Provider with Form PFML-4)

Family member Information (to be completed by the family member or authorized representative)

4. Family member's mailing address			
City	State	Zip Code	Country (if not U.S.A.)
5. Family member's Social Security Number		6. Family member's telephone number (provide area or country code) ( )	

READ AND SIGN BELOW

I have a serious health condition and thereby request that the Health Care Provider listed give a completed *Health Care Provider Certification For Care Of Family Member With Serious Health Condition* (Form PFML-4) to the employee identified on Form PFML-4, I understand that such information includes a diagnosis and prognosis of my current condition, the date it commenced, and any estimation of the amount of care that I require from the employee requesting PFML benefits as a result of my current condition.

Family member's signature	Date signed (MM/DD/YYYY)

Authorized representative

I, _____ , represent the family member in this matter as authorized by:
Print legal name

☐ Parental right ☐ Power of attorney (attach copy) ☐ Court order (attach copy) ☐ Health care proxy (attach copy)

Authorized representative's signature	Date signed (MM/DD/YYYY)

The employee should retain a copy for their own records.

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Paid Family And Medical Leave Certification For Care Of Family Member (Form PFML-4) Instructions

To Be Completed by Employee

INSTRUCTION to the EMPLOYEE: **The employee requesting Paid Family And Medical Leave (PFML) to care for family member with a serious health condition must submit the *Certification For Care Of Family Member* (Form PFML-4) with *Request For Paid Family and Medical Leave* (Form PFML-1). Fill out the employee information of this form and give to the Health Care Provider along with *Release Of Personal Health Information For Family Member* (Form PFML-3). When you receive the completed *Certification For Care Of Family Member* (Form PFML-4) from the Health Care Provider, send the completed forms and supporting documentation to The Standard.**

Employee's Name				
Employee's Address	City	State	ZIP	Phone No.
Family member's Name	Relationship of family member to employee	Family member date of birth		
Family member's Address	City	State	ZIP	Phone No.

To Be Completed By Health Care Provider

INSTRUCTIONS for HEALTH CARE PROVIDERS

This form is used to certify a serious health condition in order to qualify for Paid Family and Medical Leave (PFML). Answer each question to the best of your medical knowledge, based on your examination of the patient.

PART A: MEDICAL FACTS

1. Diagnosis _____ Primary ICD Code *(optional)* _____

   Approximate date condition commenced: _____ Probable duration of condition: _____

   Was the family member 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 family member for condition: _____

   _____

   Will the family member need to have treatment visits at least twice per year due to the condition? ☐ Yes ☐ No

   Was the family member 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 the pregnancy or delivery? ☐ Yes ☐ No Please explain: _____

   _____

   _____

   _____

4. Describe other relevant medical facts, if any, related to the condition for which the family member needs care (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment):

   _____

   _____

   _____

5. Is the family member an active service member? ☐ Yes ☐ No

   If yes, is the condition a result of military service? ☐ Yes ☐ No

PART B: AMOUNT OF CARE NEEDED: When answering these questions, keep in mind that your family member's need for care by the employee seeking leave may include assistance with basic medical, hygienic, nutritional, safety or transportation needs, or the provision of physical or psychological care:

6. Will the family member be incapacitated for a single continuous period of time, including any time for treatment and recovery? ☐ Yes ☐ No

   Estimate the beginning and ending dates for the period of incapacity: _____

   During this time, will the family member need care? ☐ Yes ☐ No

   Explain the care needed by the family member and why such care is medically necessary: _____

   _____

   _____

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Paid Family And Medical Leave Certification For Care Of Family Member (Form PFML-4)

7. Will the family member require follow-up treatments, including any time for recovery? ☐ 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: _____

   _____

   _____

   Explain the care needed by the family member, and why such care is medically necessary: _____

   _____

   _____

8. Will the family member require care on an intermittent or reduced schedule basis, including any time for recovery? ☐ Yes ☐ No

   Estimate the hours the family member needs care on an intermittent basis, if any:

   _____ hour(s) per day; _____ days per week from _____ through _____

   Explain the care needed by the family member, and why such care is medically necessary: _____

   _____

   _____

9. Will the condition cause episodic flare-ups periodically preventing the family member from participating in normal daily activities?

   ☐ Yes ☐ No

   Based upon the family member's medical history and your knowledge of the medical condition, estimate the frequency of flare-ups and the duration of related incapacity that the family member 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

   Does the family member need care during these flare-ups? ☐ Yes ☐ No

   Explain the care needed by the family member, and why such care is medically necessary _____

   _____

   _____

ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER.

Health Care Provider's Name			Date	
Address	City		State	ZIP
Phone No.	Fax No.			
Specialty/Type of Practice		License No.	State	State Identification Number

Declaration and signature

My signature attests that the information provided in this form is true and correct, that I have examined the patient and answered the questions accurately and to the best of my ability, and that I am a health care provider authorized to certify their condition.

Signature of Health Care Provider	Date

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Connecticut Paid Family and Medical Leave (PFML) Voluntary Tax Withholding Request

The tax obligations for receipt of Connecticut Paid Family and Medical Leave benefits has not yet been established by the state. However, we want to offer you the option to address any tax obligation by providing the ability to voluntarily request tax obligations withdrawn from your CT PFML benefit. You can have both Federal and Connecticut State tax withheld from your Paid Family and Medical Leave Benefits. Taxes will be withheld after deductions are taken.

- Withholding Federal and/or Connecticut State Tax is voluntary. 10% of your benefits would be withheld for Federal taxes and 5% would be withheld for Connecticut State taxes.
  - If you do not have Federal and/or Connecticut State income tax withheld, you may need to make estimated quarterly tax payments.
- The Federal and Connecticut State Tax withheld during the year will be reported on a W-2 Form that is mailed after the end of the year.

You can stop the tax withholding at any time during your benefit claim.

- If you do not want to have income tax withheld from your weekly benefits, you do not have to return this form.
- Any monies you have withheld cannot be returned to you except by the Federal or State government as part of your income tax refund.

To **start or stop** withholding 10% Federal and/or 5% Connecticut State Income Tax, complete the form below and return it to The Standard at PO Box 3877, Portland OR 97208.

Type or print: SSN: ___ – ___ – _____

First Name M.I. Last Name

Home Address (Number and Street or Rural Route)

City or Town State Zip Code

Telephone Number: ( ) –

Check All Boxes That Apply

- ☐ **Start** withholding 10% Federal Income Tax.
- ☐ **Stop** withholding 10% Federal Income Tax.
- ☐ **Start** withholding 5% CTS Income Tax.
- ☐ **Stop** withholding 5% CTS Income Tax.

Signature: _____ **Date:** _____

Declaration and signature: Some states require us to inform you that any person who knowingly and with intent to injure, defraud or deceive an insurance company, or other person, files a statement containing false or misleading information concerning any fact material hereto commits a fraudulent insurance act which is subject to civil and/or criminal penalties, depending upon the state. Such actions may be deemed a felony and substantial fines may be imposed.