TheStandard®

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

Reset

Applying For Paid Family And Medical Leave (PFML)

To Use Paid Family And Medical Leave For:
Your own 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-6
- ☐ Complete PFML-6 and give to Health Care Provider
- ☐ Health Care Provider keeps PFML-6

Complete Form PFML-7
- ☐ Complete “Employee” information at the top of PFML-7
- ☐ Provide PFML-7 to your Health Care Provider
- ☐ Health Care Provider completes 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 5 days once a complete claim is received

Please keep a copy of all pages for your records.

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Request For Delaware Paid Family And Medical Leave (Form DE PFML-1) Instructions

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

Delaware Paid Family And Medical Leave (DE PFML) Request (to be completed by the employee)

Question 9: Parental Leave means PFML taken by a Covered Individual to bond with or care for a Child during the first year of the Child's birth, adoption or placement with the Covered Individual.
Family Caregiving Leave means the PFML taken to care for a Family Member with a Serious Health Condition (illness or accident) or to address a Family Member's Qualifying Exigency.
Qualifying Exigency means PFML taken by a Covered Individual for qualified issues as defined in the FMLA, 29 CFR § 825.126, that arise in connection with a Deployment.
Medical Leave means PFML taken by a Covered Individual that is made necessary by the Covered Individual's own Serious Health Condition (illness or accident).

Question 10: Family Member means a Parent, Child or Spouse.

Child means an Employee's son or daughter as defined in the FMLA (29 CFR 825). Child includes an Employee's biological, adopted, or foster child, a stepchild, a legal ward, or a child of person standing In Loco Parentis who is either under 18 years of age; or 18 years of age or older and incapable of self-care because of a mental or physical disability.

Parent means an Employee's parent as defined under the FMLA. Parent includes an Employee's biological, adoptive, step, foster father or mother, or any other individual who stood In Loco Parentis to the Employee when the Employee was a son or daughter as defined by FMLA. This term does not include parents "in law".

Spouse means the Employee's husband or wife as defined or recognized in the state where the individuals were married and includes persons in common law or same-sex marriage. Spouse also includes the Employee's husband or wife in a marriage that was validly entered into outside of the United States if the marriage could have occurred here in at least one State.

Question 11: If dates are "Continuous", the employee must provide the start and end dates of the requested DE PFML. These dates should be the actual dates that the DE 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 DE 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 DE 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 DE PFML request to their employer with less than 30 days' advance notice from the start date of the DE 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 DE PFML. Include the type/name of income and how much. Example PTO from employer for $500.00 a week.

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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 DE 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 means a Covered Individual's remuneration for Delaware based employment with the Employer as determined for purposes of old-age, survivors, and disability insurance for employees and employers under the Federal Insurance Contribution Act, 26 U.S.C. Chapter 21.
Average Weekly Wage means the employee's average gross earnings, that are earned in Delaware as determined under the Federal Insurance Contribution Act, whether salaried or hourly (prior to any payroll deductions or withholdings) as reported on the quarterly Hours and Wage report *for the 4 completed calendar quarters immediately preceding the filing of a claim application*. If 4 completed calendar quarters are unavailable, the Division will accept the weekly average of the 3 completed calendar quarter quarterly Hours & Wage reports immediately preceding the filing of a claim application.

Question 12: To qualify for reimbursement from us, the Employer must pay Wage continuation to the Covered Individual that is equal to or greater than the Weekly Benefit Amount.

Question 13: No PFML Benefits are payable for any period for which the Covered Individual is eligible for unemployment insurance benefits under 19 Del.C. Section 3311 et seq.

No PFML Benefits are payable for any period for which the Covered Individual is eligible for temporary disability benefits under Workers' Compensation Act, 19 Del.C. Section 2301 et seq. due to a workplace accident or injury.

Affirmation employee is eligible for DE PFML:
To be eligible for any family and medical leave, an employee must be in employer's employment in the state of DE for at least 12 months and been employed for at least 1,250 hours of service with the employer during the previous 12-month period. For purposes of determining whether an individual meets the service hours requirement, the legal standards established under the FMLA apply. Employee must work primarily in Delaware ("primarily" meaning 60% or more of their time each calendar quarter).

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

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

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

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

10. The family member is employee's: ☐ Child ☐ Spouse ☐ Parent

11. Will DE 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)

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. Are you eligible for, or receiving, Workers' Compensation (WC), Unemployment Insurance (UI) or Personal Injury Protection (PIP) benefits due to an injury from an automobile accident? ☐ Yes ☐ No If yes, indicate which benefit: ☐ (WC) ☐ (UI) ☐ (PIP)

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

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

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Request For Delaware Paid Family And Medical Leave (Form DE 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)

Declaration and signature
Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

Employee's signature	Date signed (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 DE 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? ☐ Yes ☐ No Medicare taxes? ☐ Yes ☐ No
8c. Has employee met the annual limit to Social Security max. contribution? ☐ Yes ☐ No ☐ N/A

9. Check Days Normally Worked ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday ☐ Sunday
Indicate Hours Normally Worked _____ _____ _____ _____ _____ _____ _____

10. List the dates of any period a week or longer that the employee is not scheduled or able to work due to lapses in seasonal operations, school breaks, or other suspensions or cessations of business operations while on PFML leave, including federal, state, local or Employer designated holidays: (example: December 18 - January 1 and March 25 - March 31 or N/A if not applicable)

_____

11. Will Wage continuation be paid to the Covered Individual that is equal to or greater than the Weekly Benefit Amount? ☐ Yes ☐ No
If yes, provide dates: _____

12. If employee received or will receive Wage continuation while on DE PFML, will employer be requesting reimbursement? ☐ Yes ☐ No
If yes, provide dates: _____

13. Has the employee filed for Workers' Compensation Benefits or Unemployment Benefits? ☐ Yes ☐ No
If yes, provide benefit dates: _____

14. DE PFML policy number

DE 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 requirements for Delaware Paid Family And Medical Leave.

I am the person authorized to sign as the employer of the employee requesting DE 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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Paid Family and Medical Leave
Release of Information for Own Serious Health Condition
(Form PFML-6)

Notice to the Employee About Use of this Authorization

As you may know, the Paid Family And Medical Leave Act (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 PFML medical certification. For 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 PFML administration and minimize the need to contact you during leave, we have developed the attached 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 PFML. You are not required to complete and sign the Authorization for The Standard to process your request for 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 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 Health Care 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.

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Paid Family And Medical Leave Certification for Own Serious Health Condition (Form PFML-7)

Employee's Name	Date of Birth

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: _____

   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 _____

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Paid Family And Medical Leave Certification for Own Serious Health Condition (Form PFML-7)

Employee's Name	Date of Birth

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

We want to offer you the option to address any tax obligation by providing the ability to voluntarily request tax obligations withdrawn from your Delaware PFML benefit. You can have both Federal and Delaware State tax withheld from your Paid Family and Medical Leave Benefits. Taxes will be withheld after deductions are taken.

- Withholding Federal and/or Delaware State Tax is voluntary. 10% of your benefits would be withheld for Federal taxes and 3% would be withheld for Delaware State taxes.
  - If you do not have Federal and/or Delaware State income tax withheld, you may need to make estimated quarterly tax payments.
- The Federal and Delaware State Tax withheld during the year will be reported on a Tax 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 3% Delaware 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 3% DE State Income Tax.
- ☐ **Stop** withholding 3% DE State 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.

Print