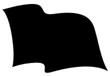

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PO Box 3877 Portland OR 97208

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 Maine Paid Family And Medical Leave (Form ME PFML-1) Instructions

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

Maine Paid Family And Medical Leave (ME PFML) Request (to be completed by the employee)

Question 9: Parental Leave (Bonding) means PFML taken to bond with a Child during the first twelve months after the Child's birth; adoption, or foster care placement with the Covered Individual; for placement of a child 16 years of age or less with the Employee or with the Employee's Domestic Partner in connection with the adoption of the child by the employee or the Employee's Domestic Partner.

Care of a Family Member means PFML taken by an Applicant to care for a Family Member with a Serious Health Condition.

Safe Leave means any PFML taken because the Covered Individual or a Family Member is a victim of violence, assault, sexual assault under Title 17-A, chapter 11, stalking or any act that would support an order for protection under Title 19-A, chapter 103. Safe leave applies if the Covered Individual is using the PFML to protect the Covered Individual or the Family Member by:

1. Seeking an order for protection under Title 19-A, chapter 103;
2. Obtaining medical care or mental health counseling for the Covered Individual or for the Family Member to address physical or psychological injuries resulting from the act of violence, assault, sexual assault or stalking or act that would support an order for protection under Title 19-A, chapter 103;
3. Making the Covered Individual's or Family Member's home secure from the perpetrator of the act of violence, assault, sexual assault or stalking or act that would support an order for protection under Title 19-A, chapter 103 or seeking new housing to escape the perpetrator; or
4. Seeking legal assistance to address issues arising from the act of violence, assault, sexual assault or stalking or act that would support an order for protection under Title 19-A, chapter 103 or attending and preparing for court-related proceedings arising from the act or crime.

Military Leave means a need arising out of a Military Member's active duty service or notice of an impending call or order to active duty in the United States armed forces, or due to the death or Serious Health Condition of a Spouse, Domestic Partner, Parent, Sibling, or Child if the Spouse, Domestic Partner, Parent, Sibling or child as a member of the state military forces, as defined in Title 37-B, section 102, or the United States Armed Forces, including the National Guard and Reserves, dies or incurs a Serious Health Condition while on active duty.

Military Exigency means providing for the care or other needs of the Family Member's child or other dependent, making financial or legal arrangements for the Family Member, attending counseling, attending military events or ceremonies, spending time with the Family Member during a rest and recuperation leave or following return from deployment or making arrangements following the death of the Military Member.

Medical Leave means PFML taken by an Applicant that is made necessary by the Applicant's own Serious Health Condition which renders them unable to work.

Question 10: Family Member means, with respect to a Covered Individual or Spouse or Domestic Partner of a Covered Individual's Child; Parent; Grandparent; Grandchild; Sibling; Spouse or Domestic Partner; or an Individual with whom the Covered Individual has a Significant Personal Bond that is or is like a family relationship, regardless of biological or legal relationship.

Child means a Covered Individual's or a Spouse's or Domestic Partner's child regardless of age: whose parentage has been determined under the Maine Parentage Act or any other biological child, adopted child, foster child or stepchild, to whom they stood in loco parentis, to whom they had under legal guardianship; or to whom they stood in any of these relationships when the individual was a minor child.

Grandchild means a Covered Individual's or a Spouse's or Domestic Partner's grandchild, including a legal grandchild, biological grandchild, adoptive grandchild, foster grandchild, step-grandchild, or de facto grandchild.

Grandparent means a Covered Individual's or a Spouse's or Domestic Partner's grandparent, including a legal grandparent, biological grandparent, adoptive grandparent, foster grandparent, step-grandparent, or de facto grandparent.

Parent means with respect to a Covered Individual's or a Spouse's or Domestic Partner's parent, including a legal parent, biological parent, adoptive parent, foster parent, stepparent, de facto parent or legal guardian or a person who stood in loco parentis when the Covered Individual or Spouse or Domestic Partner was a minor child.

Domestic Partner means an unmarried adult with whom the Covered Individual is domiciled under a long-term arrangement that evidences a commitment to remain responsible indefinitely for each other's welfare.

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Employment Information (to be completed by the employee)

Significant Personal Bond means significant personal bond is one that, when examined under the totality of the circumstances, is like a family relationship, regardless of biological or legal relationship. This bond may be demonstrated by, but is not limited to the following factors, with no single factor being determinative:

1. Shared personal financial responsibility, including shared leases, common ownership of real or personal property, joint liability for bills or beneficiary designations;
2. Emergency contact designation of the Employee by the other individual in the relationship or the emergency contact designation of the other individual in the relationship by the Employee;
3. The expectation to provide care because of the relationship or the prior provision of care;
4. Cohabitation and its duration and purpose;
5. Geographic proximity; and Any other factor that demonstrates the existence of a family-like relationship.

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

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 ME PFML. Include the type/name of income and how much. Example PTO from employer for $500.00 a week.

Question 20: Wages include, but are not limited to, an Employee’s Maine based remuneration for personal services, salary, wages, tips, and gratuities; severance and terminal pay; commissions and bonuses; and other eligible compensation. Wages are calculated in the same manner as Maine unemployment wages in 26 M.R.S. § 1043(19)(B-E). Wages include remuneration for services performed in the State or wages which are otherwise subject to Maine unemployment tax pursuant to 26 M.R.S. §1043 (11) (A) and (D).

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.

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

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

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

Question 8: Wages include, but are not limited to, an Employee's Maine based remuneration for personal services, salary, wages, tips, and gratuities; severance and terminal pay; commissions and bonuses; and other eligible compensation. Wages are calculated in the same manner as Maine unemployment wages in 26 M.R.S. § 1043(19)(B-E). Wages include remuneration for services performed in the State or wages which are otherwise subject to Maine unemployment tax pursuant to 26 M.R.S. §1043 (11) (A) and (D).

Wage Credits means the amount of Wages Paid within an Applicant's Base Period for Covered Employment.

Average Weekly Wage means the aggregate total Wages paid in Maine for the Covered Individual's Base Period, divided by 52.

Base Period means the first four of the last five completed calendar quarters immediately preceding the first Day of the Covered Individual's Benefit Year.

Question 9: Scheduled Workweek means the number of hours an Employee is scheduled to work in a particular week. A self-employed individual who has elected coverage and a salaried Employee as defined by 26 M.R.S. § 663 (3) (K) have a scheduled workweek of 40 hours, Monday-Friday, 8 hours per Day.

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

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.

The Employer is not eligible for reimbursement of vacation, sick pay, paid time off or disability insurance paid to the Applicant.

Question 13: PFML Benefits are reduced for any portion of a typical work week for which the Applicant is receiving or has received Maine unemployment insurance benefits or workers' compensation under the Maine Department of Labor.

Declaration and Signature - Affirmation employee is eligible for ME PFML

To be eligible for any family and medical leave, an employee must be a Covered Employee.

Covered Individual means an Employee who has earned Wages equal to at least 6 times the SAWW (state average weekly wage) in effect at the time of Application during the Base Period and who meets the administrative requirements and files a Claim, or a person who elects coverage and meets the requirements of section 850-G. A Self-Employed Individual's reported Wages must meet the minimum threshold for all other covered individuals to be considered a covered individual.

Employee means a person who may be permitted, required, or directed by an Employer in consideration of direct or indirect gain or profit to engage in any employment in Maine, but does not include any independent contractor. Employee includes individuals the Employer has engaged through an employee leasing contractual arrangement described in 32 M.R.S. Ch. 125.

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

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

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Request For Maine Paid Family And Medical Leave (Form ME 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 ME PFML (if available)
8. Employee's gender ☐ Male ☐ Female ☐ Not designated/Other
9. Reason for ME PFML request:
   Parental (Bonding) Leave: ☐ New child ☐ Adoption/Foster child
   ☐ **Care for Family Member with a Serious Health Condition**
   ☐ **Safe Leave**
   Own Serious Health Condition:
   ☐ Own Serious Health Condition due to pregnancy ☐ Own Serious Health Condition (other)
   Military Leave: ☐ Qualifying Military Exigency ☐ Care or Death of an Active Military Member
10. The family member is employee's: ☐ Child ☐ Spouse ☐ Sibling ☐ Parent ☐ Grandparent ☐ Grandchild ☐ Son-in-law or Daughter-in-law
    ☐ Individual who has a personal relationship with the Applicant that creates an expectation and reliance that the Applicant care for the individual without compensation, whether or not the Applicant and the individual reside together.
11. Will ME PFML be used for a Continuous period of time, Intermittently and/or on a Reduced Leave Schedule?
    ☐ Continuous ______ / ________ / __________ start date (MM/DD/YYYY) __________ / ________ / _________ end date (MM/DD/YYYY) ☐ Dates are estimated
    ☐ 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 receiving Workers' Compensation, Unemployment Insurance Benefits or Social Security disability benefits? ☐ Yes ☐ No
19. List income or financial benefits you will be receiving while on ME PFML, source of pay and amount.
20. **If you have been working for your employer for less than five quarters (15 months):**
    Have you received higher Wages (inclusive of salary, bonuses and commissions etc.) from a prior employer during the last five quarters (15 months)?
    ☐ Yes* ☐ No
    *If yes, provide us with paystubs (W2s are not sufficient proof).
21. Have you taken any leave in the last 12 months? ☐ Yes ☐ No
22. If yes list dates and type of leave.

Disclosure statement: Information regarding ME 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 Maine Paid Family And Medical Leave (Form ME 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
It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

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 ME 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. Scheduled Workweek:
Check Days Normally Worked ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday ☐ Sunday
Indicate Hours Normally Worked _______ _______ _______ _______ _______ _______ _______
List the dates of any period a week or longer that the employee is not expected to work due to a lapse in seasonal operations, school breaks, or other scheduled business closures (example: December 18-January 1 and March 25-March 31, or N/A if not applicable):
____

10. If the work schedule is so variable that it is difficult to determine the scheduled workweek:
What is the average number of hours worked per week? _______
* The average should be calculated based on actual hours worked during the 12 weeks prior to the first absence. If the employee has not been employed for 12 weeks, provide the average number of hours worked per week during their period of employment.

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 ME 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. Has the employee taken any leave in the last 12 months? ☐ Yes ☐ No
If yes list dates and type of leave: ____

15. ME PFML policy number

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

Standard Insurance Company

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PO Box 3877 Portland OR 97208

**Request For
Maine Paid Family And Medical Leave
(Form ME 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) continued

Declaration and signature - Affirmation employee is eligible for ME PFML

☐ I affirm the employee meets the eligibility requirements for Maine Paid Family and Medical Leave.

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

Standard Insurance Company

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PO Box 3877 Portland OR 97208

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.

GINA Disclaimer: 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 employees or their family members, 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 is defined to include 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.

PART A: MEDICAL FACTS

1. Diagnosis: ______________________ Primary ICD Code: ______________________

   (Do not include the Diagnosis or Primary ICD Code for patients who are working in the following states: CT, DE, MA, MN, WA. This request is made to ensure compliance with applicable laws and guidelines.)

   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: ______________________

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

Employee's Name	Date of Birth

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 ____________

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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Maine 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 Maine PFML benefit. You can have both Federal and Maine State tax withheld from your Paid Family and Medical Leave Benefits. Taxes will be withheld after deductions are taken.

- Withholding Federal and/or Maine State Tax is voluntary. 10% of your benefits would be withheld for Federal taxes and 5% would be withheld for Maine State taxes.
  - If you do not have Federal and/or Maine State income tax withheld, you may need to make estimated quarterly tax payments.
- The Federal and Maine 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 5% Maine 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.
☐ **Start** withholding 5% ME State Income Tax.
☐ **Stop** withholding 10% Federal Income Tax.
☐ **Stop** withholding 5% ME 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.