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 For:
Your own serious health condition

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

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

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

Please keep a copy of all pages for your records.

Standard Insurance Company

866.756.8116 Tel 866.751.5174 Fax
PO Box 3877 Portland OR 97208

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.

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.

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

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.

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

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 **Standard Insurance Company** **PO Box 3877** **Portland, OR 97208** **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	

Standard Insurance Company

866.756.8116 Tel 866.751.5174 Fax
PO Box 3877 Portland OR 97208

Washington Paid Family and Medical Leave
Release of Information for Own Serious Health Condition
(Form WA PFML-6)

Notice to the Employee About Use of this Authorization

As you may know, the Washington Paid Family And Medical Leave Act (WA 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 WA PFML medical certification. For WA 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 WA PFML administration and minimize the need to contact you during leave, we have developed the attached WA 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 WA PFML. You are not required to complete and sign the Authorization for The Standard to process your request for WA 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 WA PFML clarification or authentication, please review the Authorization carefully and complete, sign and return the Authorization to the address above.

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

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

Name (please print)	
Signature of Claimant/Representative	Date

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

Standard Insurance Company

866.756.8116 Tel 866.751.5174 Fax
PO Box 3877 Portland OR 97208

Washington Paid Family And Medical Leave Certification for Own Serious Health Condition (Form WA 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 Washington Paid Family and Medical Leave (WA PFML). Qualifying serious health conditions and authorized healthcare providers are described below. Answer each question to the best of your medical knowledge, based on your examination of the patient.

SERIOUS HEALTH CONDITION

A "serious health condition" is defined in RCW 50A.05.010 and healthcare providers should review the complete definition before certifying a patient's condition. Generally, a serious health condition could include an illness, injury, impairment, or physical or mental condition that involves:

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

Continuing treatment by a healthcare provider: A serious health condition involving continuing treatment by a health care provider includes any one or more of the following:

- Incapacity; A period of incapacity of more than three consecutive days and subsequent treatment or period of incapacity relating to the same condition. Incapacity means an inability to work, attend school, or perform other regular daily activities because of a serious health condition, treatment of that condition or recovery from it, or subsequent treatment in connection with such inpatient care.
- Pregnancy: Any period of incapacity due to pregnancy, or for prenatal care;
- Chronic conditions: Any period of incapacity or treatment for such incapacity due to a chronic serious health condition. A chronic serious health condition is one which:
    - Continues over an extended period of time, including recurring episodes of a single underlying condition;
    - Requires periodic visits to a health care provider; and
    - May cause episodic rather than a continuing period of incapacity, including asthma, diabetes, and epilepsy
- Permanent/Long-term: A period of incapacity which is permanent or long-term due to a condition for which treatment may not be effective. The employee or family member must be under the continuing supervision of, but need not be receiving active treatment by, a health care provider, including Alzheimer's, a severe stroke, or the terminal stages of a disease; or
- Multiple treatments: Any period of absence to receive multiple treatments, including any period of recovery from the treatments.
- Substance abuse may be a serious health condition if the treatment meets other requirements in this definition.

HEALTHCARE PROVIDERS

Healthcare provider is defined in RCW 50A.05.010 and WAC 192-500-090 and means:

- A physician or an osteopathic physician who is licensed to practice medicine or surgery, as appropriate, by the state in which the physician practices;
- Nurse practitioners, nurse-midwives, midwives, clinical social workers, physician assistants, podiatrists, dentists, clinical psychologists, optometrists, and physical therapists licensed to practice under state law and who are performing within the scope of their practice as defined under state law by the state in which they practice;
- A health care provider listed above who practices in a country other than the United States, who is authorized to practice in accordance with the law of that country, and who is performing within the scope of the health care provider's practice as defined under such law; or
- Any other provider permitted to certify the existence of a serious health condition under the federal FMLA.

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

Standard Insurance Company

866.756.8116 Tel 866.751.5174 Fax
PO Box 3877 Portland OR 97208

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

Employee's Name	Date of Birth

PART A: MEDICAL FACTS

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

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

   Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility? ☐ Yes ☐ No

   If so, dates of admission: _____

   _____

   Date(s) you treated the patient for condition: _____

   _____

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

   Was the patient referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)? ☐ Yes ☐ No

   If so, state the nature of such treatments and expected duration of treatment: _____

   _____

2. Is the medical condition pregnancy? ☐ Yes ☐ No If so, expected/actual delivery date: _____
3. Complications with pregnancy or delivery? ☐ Yes ☐ No If yes please explain: _____

   _____

   _____

   _____

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

   _____

   _____

   _____

PART B: AMOUNT OF LEAVE NEEDED

5. Will the employee be incapacitated for a single continuous period of time due to his/her medical condition, including any time for treatment and recovery? ☐ Yes ☐ No

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

6. Will the employee need to attend follow-up treatment appointments or work part-time or on a reduced schedule because of the employee's medical condition? ☐ Yes ☐ No

   If so, are the treatments or the reduced number of hours of work medically necessary? ☐ Yes ☐ No

   Estimate treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including any recovery period: _____

   _____

   _____

   _____

   Estimate the part-time or reduced work schedule the employee needs, if any:

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

Standard Insurance Company

866.756.8116 Tel 866.751.5174 Fax
PO Box 3877 Portland OR 97208

Washington Paid Family And Medical Leave Certification for Own Serious Health Condition (Form WA 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			
Address	City	State	ZIP
Phone No.	Fax No.		
Specialty/Type of Practice		License No.	

I declare under penalty of perjury that the information provided in this form is true and correct, that the patient's condition meets the definition of "serious health condition" [RCW 50A.05.010], and that I am a healthcare provider authorized to certify their condition [RCW 50A.05.010 ; WAC 192-500-090].

Signature of Health Care Provider	Date

Print