



# The Standard®

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:

Assist family members due to another family member's active military duty or  
impending active duty abroad

#### 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-5

- Complete PFML-5 and collect supporting documentation

#### Send forms and documents

- Send completed forms and supporting documentation to The Standard
- The Standard accepts or denies claim within 5 days once a complete claim is received.

**Please keep a copy of all pages for your records.**

- 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.

**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.**

**TO BE COMPLETED BY THE EMPLOYEE**

Employee's name (first name, middle initial, last name)	Employee's date of birth (MM/DD/YYYY)
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**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 <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Not designated/Other	
9. Reason for DE PFML request: <b>Parental Leave (Bonding):</b> <input type="checkbox"/> New child <input type="checkbox"/> Adoption/Foster child <b>Family Caregiving Leave:</b> <input type="checkbox"/> Care for Family Member with a Serious Health Condition <input type="checkbox"/> Military exigency <b>Medical Leave:</b> <input type="checkbox"/> Own Serious Health Condition due to pregnancy <input type="checkbox"/> Own Serious Health Condition (other)				
10. The family member is employee's: <input type="checkbox"/> Child <input type="checkbox"/> Spouse <input type="checkbox"/> Parent				
11. Will DE PFML be used for a Continuous period of time, Intermittently and/or on a Reduced Leave Schedule? <input type="checkbox"/> Continuous _____ / _____ / _____ start date (MM/DD/YYYY) _____ / _____ / _____ end date (MM/DD/YYYY) <input type="checkbox"/> Dates are estimated <input type="checkbox"/> Intermittent (separate, non-consecutive time) Days/hours(s) requested: _____ <input type="checkbox"/> Dates are estimated <input type="checkbox"/> Reduced Leave Schedule (consistent but reduced work schedule for multiple weeks) Days/hours(s) requested: _____ (example: 2 days per week, or 4 hours per day, or every Monday) <input type="checkbox"/> Dates are estimated				

**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? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, indicate which benefit: <input type="checkbox"/> (WC) <input type="checkbox"/> (UI) <input type="checkbox"/> (PIP)				
19. Have you taken any leave in the last 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No		20. If yes list dates and type of leave.		
<b>Disclosure statement:</b> Information regarding DE PFML benefits received by the employee, such as payments received and types of leave, will be provided to the employer.				

**TO BE COMPLETED BY THE EMPLOYEE**

Employee's name (first name, middle initial, last name)	Employee's date of birth (MM/DD/YYYY)
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**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)
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**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? <input type="checkbox"/> Yes <input type="checkbox"/> No Medicare taxes? <input type="checkbox"/> Yes <input type="checkbox"/> No							
8c. Has employee met the annual limit to Social Security max. contribution? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A							
9. Check Days Normally Worked	<input type="checkbox"/> Monday	<input type="checkbox"/> Tuesday	<input type="checkbox"/> Wednesday	<input type="checkbox"/> Thursday	<input type="checkbox"/> Friday	<input type="checkbox"/> Saturday	<input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide dates: _____							
12. If employee received or will receive Wage continuation while on DE PFML, will employer be requesting reimbursement? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide dates: _____							
13. Has the employee filed for Workers' Compensation Benefits or Unemployment Benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide benefit dates: _____							
14. DE PFML policy number _____							
DE PFML insurance carrier's name and mailing address <b>Standard Insurance Company PO Box 3877, Portland, OR 97208 866-751-5174 Fax</b>							
<b>Declaration and signature</b>							
<input type="checkbox"/> 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  
Certification for Military Exigency  
(Form PFML-5)**

Employee's Name				
Employee's Mailing Address	Street	City	State	Zip Code
Relationship of covered military member to employee				
Address of covered military member on active duty or call to active duty status		City	State	Zip Code
Name of covered military member on active duty or call to active duty status		Dates of covered military member's active duty service		
<p>Please check one of the following:</p> <p><input type="checkbox"/> A copy of the covered military member's active duty orders is attached.</p> <p><input type="checkbox"/> Other documentation from the military certifying that the covered military member is on active duty (or has been notified of an impending call to active duty) in support of a contingency operation is attached. Such documentation may include a copy of a meeting announcement for informational briefings sponsored by the military, a document confirming an appointment with a counselor or school official, or a copy of a bill for services for the handling of legal or financial affairs.</p> <p><input type="checkbox"/> I have previously provided my employer with sufficient documentation confirming the covered military member's active duty or call to active duty status in support of a contingency operation.</p>				
<p><b>Description of qualifying exigency</b> (On page 2 of this form is the description of a "qualifying exigency." Does the need for leave qualify under any of the categories described? If so, please check the applicable category.)</p> <p><input type="checkbox"/> (1) <input type="checkbox"/> (2) <input type="checkbox"/> (3) <input type="checkbox"/> (4) <input type="checkbox"/> (5) <input type="checkbox"/> (6) <input type="checkbox"/> (7) <input type="checkbox"/> (8) <input type="checkbox"/> (9) <input type="checkbox"/> (10)</p>				
<p>Describe the reason you are requesting leave due to a qualifying exigency (including the specific reason you are requesting leave):</p> <p>_____</p>				
<p>Approximate date exigency commenced or will commence _____</p> <p>Probable duration of exigency _____</p> <p>Will you need to be absent from work for a single continuous period of time due to the qualifying exigency? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If so, estimate the beginning and ending dates for the period of absence _____</p> <p>Will you need to be absent from work periodically to address this qualifying exigency? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Estimate the frequency and duration of each period of absence due to the qualifying exigency (e.g. 3x per month lasting 4 hours):</p> <p>Frequency: _____ times per _____ week(s) _____ month(s)</p> <p>Duration: _____ hour(s) or _____ day(s) per event</p>				

**Declaration and signature**

I certify that the answers I have made to the above questions are complete and true to the best of my knowledge and belief. I acknowledge that I have read the fraud notice on page 3 of this form.

Signature of Employee

Date

## **PFML Description of a Qualifying Exigency**

Eligible employees may take Paid Family And Medical Leave (PFML) while the employee's spouse, child, or parent is on active duty or call to active duty status for one or more of the following qualifying exigencies:

A need arising out of a covered individual's family member's active duty service or notice of an impending call or order to active duty in the Armed Forces including, but not limited to,

1. Short-Notice Deployment
2. Military Events and Related Activities
3. Childcare and School Activities
4. Arrangements for Family Care
5. Financial and Legal Arrangements
6. Counseling
7. Rest and Recuperation
8. Post-Deployment Activities
9. Family Member Injured in Combat
10. Additional qualifying events as defined in the federal Family and Medical Leave Act.

The fraud notices shown apply to your paid family and medical leave claim submissions.

**COLORADO**

It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to the policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

**CONNECTICUT**

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.

**DELAWARE**

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.

**MASSACHUSETTS**

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**NEW YORK**

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

**OREGON**

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.

**WASHINGTON**

It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

**ALL OTHER STATES**

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.



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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

- |   |   |
|---|---|
| <input type="checkbox"/> <b>Start</b> withholding 10% Federal Income Tax. | <input type="checkbox"/> <b>Start</b> withholding 3% DE State Income Tax. |
| <input type="checkbox"/> <b>Stop</b> withholding 10% Federal Income Tax.  | <input type="checkbox"/> <b>Stop</b> 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.