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 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.

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Request For Massachusetts Paid Family And Medical Leave (Form MA PFML-1) Instructions

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

Massachusetts Paid Family And Medical Leave (MA PFML) Request (to be completed by the employee)

Question 10: Family member means the spouse, domestic partner, child, parent or parent of a spouse or domestic partner of the employee; a person who stood in *loco parentis* to the employee when the employee was a minor child; or a grandchild, grandparent or sibling of the employee.
Child means a biological, adopted or foster child, a stepchild or legal ward, a child to whom the employee stands in *loco parentis*.
Grandchild means a child of the employee's child.
Grandparent means a parent of the employee's parent.
Parent means the biological, adoptive, step-brother or step-sister of the employee.
Spouse means a husband or wife or domestic partner of an employee.

Question 11: If dates are "Continuous", the employee must provide the start and end dates of the requested MA PFML. These dates should be the actual dates that the MA 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 MA 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 MA 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 MA PFML request to their employer with less than 30 days' advance notice from the start date of the MA 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 MA 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 MA 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 Massachusetts Paid Family And Medical Leave within five days to the employee with an explanation that the claim should be re-submitted when all information is available.

Employee signs and dates, before giving this form to their employer to complete Part B.

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

The employer of the employee requesting MA 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.

Average Weekly Wage will be based on the weekly Wages in effect with the Employer on the day immediately preceding the date Family or Medical Leave under the Group Policy begins. For former Employees, the Average Weekly Wage will be based on Wages that were in effect on the last day the former Employee was in the employment of the Employer. For Covered Individuals who are paid hourly, the Average Weekly Wage is based on the hourly pay rate multiplied by the number of hours regularly scheduled to work for the Employer per week, but not more than 40 hours. If the Covered Individual does not have regular work hours, the Average Weekly Wage is based on the average number of hours worked per week for the Employer during the preceding 52 calendar weeks (or during the period of employment with the Employer if less than 52 weeks), but not more than 40 hours. If a Covered Individual has multiple Employers, the Average Weekly Wage will be calculated for each employer or Covered Business Entity separately.

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

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

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

9. Reason for MA PFML request: ☐ Bond with child ☐ Care for family member ☐ Military qualifying event ☐ Own serious health condition ☐ Care of a family member who is a service member

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

11. Will MA PFML be for a continuous period of time and/or periodic?

☐ Continuous _____ / _____ / _____ _____ / _____ / _____ ☐ Dates are estimated
MA PFML start date (MM/DD/YYYY) MA PFML end date (MM/DD/YYYY)

Identify dates periodic MA PFML will be taken:

☐ Periodic _____ ☐ Dates are estimated

If providing less than 30 days advanced notice to the employer, please explain:_____

_____

12. Date employer was notified. If providing less than 30 day's advance notice to the employer, please explain:

Employment Information (to be completed by the employee)

13. Business name	14. Employee's date of hire (MM/DD/YYYY)	14a. Employee's last day of work (MM/DD/YYYY)

15. 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 Benefits? ☐ Yes ☐ No

18. List pay you will be receiving while on MA 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 MA PFML benefits received by the employee, such as payments received and types of leave, will be provided to the employer.

Declaration and signature

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.

I am hereby making a request for paid family and medical leave benefits under the Massachusetts 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.

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Request For
Massachusetts Paid Family And Medical Leave
(Form MA PFML-1)

TO BE COMPLETED BY THE EMPLOYEE

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

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

1. Business's full legal name and mailing address			
Mailing address			
City	State	Zip code	Country (if not U.S.A.)
2. Employer's FEIN			
3. Employer's EIN	4. Employer's contact name for questions related to MA PFML		
5. Employer's contact telephone number ( )	6. Employer's contact email address		
7. Employee's date of hire (MM/DD/YYY)	7a. Employee's last day of work (MM/DD/YYY)		
8. Employee's Average Weekly Wage			
9. Employee's Typical Work Week Hours			
10a. Check Days Normally Worked ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday ☐ Sunday			
10b. Is employee hourly or salaried? ☐ Hourly ☐ Salaried			
11. List the last date the employee will receive pay, for example the last date through which sick leave benefits, if any, will be paid.			
12a. What type of paid benefits will the employee receive while on MA PFML? Include the last date through which any compensation will be paid.			
12b. If, while on fully-insured MA PFML, the employee will receive wages in the form of sick leave, PTO, vacation or an extended illness leave bank that is at least equal to the benefit under the Group Policy, will the employer be requesting reimbursement? ☐ Yes ☐ No			
13. Is the employee taking federal Family Medical Leave Act (FMLA)? ☐ Yes ☐ No	14. MA PFML policy number		
MA 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 Massachusetts Paid Family And Medical Leave. I am the person authorized to sign as the employer of the employee requesting MA 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		

Please check one of the following:

☐ A copy of the covered military member's active duty orders is attached.
☐ 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.
☐ 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.

Description of qualifying exigency *(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.)*

☐ (1) ☐ (2) ☐ (3) ☐ (4) ☐ (5) ☐ (6) ☐ (7) ☐ (8)

Describe the reason you are requesting leave due to a qualifying exigency (including the specific reason you are requesting leave):

Please attach any available written documentation which supports the need for leave; 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.

Available written documentation is attached. ☐ Yes ☐ None Available

Approximate date exigency commenced or will commence _____

Probable duration of exigency _____

Will you need to be absent from work for a single continuous period of time due to the qualifying exigency? ☐ Yes ☐ No

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

Will you need to be absent from work periodically to address this qualifying exigency? ☐ Yes ☐ No

Estimate the frequency and duration of each period of absence due to the qualifying exigency (e.g. 3x per month lasting 4 hours):

Frequency: _____ times per _____ week(s) _____ month(s)

Duration: _____ hour(s) or _____ day(s) per event

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

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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.

Some states require us to provide the following information to you:

COLORADO RESIDENTS

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 RESIDENTS

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.

MASSACHUSETTS RESIDENTS

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.

OREGON RESIDENTS

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 RESIDENTS

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.

ALL OTHER RESIDENTS

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

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

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

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

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

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

Type or print: SSN: ___ – ___ – _____

First Name M.I. Last Name

Home Address (Number and Street or Rural Route)

City or Town State Zip Code

Telephone Number: ( ) – _____

Check All Boxes That Apply

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

Signature: _____ **Date:** _____

Declaration and signature: 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.

Print