



**To Use Massachusetts Paid Family And Medical Leave To:  
Bond with a newborn, a newly adopted or fostered child**

**Complete Form MA PFML -1**

- Complete MA PFML-1, Part A
- Provide MA PFML-1 to employer
- Employer completes MA PFML-1, Part B and returns to you within 3 days

**Complete Form MA PFML -2**

- Complete MA PFML-2 and collect supporting documentation

**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.**

- 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.**

**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.**

**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 MA PFML (if available)		8. Employee's gender <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Not designated/Other		
9. Reason for MA PFML request: <input type="checkbox"/> Bond with child <input type="checkbox"/> Care for family member <input type="checkbox"/> Military qualifying event <input type="checkbox"/> Own serious health condition <input type="checkbox"/> Care of a family member who is a service member				
10. The family member is employee's: <input type="checkbox"/> Child <input type="checkbox"/> Spouse or registered domestic partner <input type="checkbox"/> Sibling <input type="checkbox"/> Parents and legal guardians (or spouse's parent) <input type="checkbox"/> Grandparent <input type="checkbox"/> Grandchild				
11. Will MA PFML be for a continuous period of time and/or periodic? <input type="checkbox"/> Continuous ____ / ____ / ____      ____ / ____ / ____ <input type="checkbox"/> 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: <input type="checkbox"/> Periodic _____ <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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)
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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.

**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 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/YYYY)		7a. Employee's last day of work (MM/DD/YYYY)	
8. Employee's Average Weekly Wage			
9. Employee's Typical Work Week Hours			
10a. 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			
10b. Is employee hourly or salaried? <input type="checkbox"/> Hourly <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No			
13. Is the employee taking federal Family Medical Leave Act (FMLA)? <input type="checkbox"/> Yes <input type="checkbox"/> No		14. MA PFML policy number	
MA PFML insurance carrier's name and mailing address <b>Standard Insurance Company</b> <b>PO Box 3877</b> <b>Portland, OR 97208</b> <b>866-751-5174 Fax</b>			
<b>Declaration and signature</b> <input type="checkbox"/> 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			

If the employee is requesting Massachusetts Paid Family And Medical Leave (MA PFML) to bond with a newborn, an adopted child or a foster child, the employee must submit the *Bonding Certification* (Form MA PFML-2) with the *Request For Massachusetts Paid Family And Medical Leave* (Form MA PFML-1).

### **BONDING CERTIFICATION (to be completed by the employee)**

*The employee requesting MA PFML must complete all applicable requested information.*

*Send completed forms and supporting documentation to The Standard.*

**If this form is being submitted in advance (pre-submitting) and some information is unknown, the insurance carrier will contact the employee and explain how to provide the required additional information.**

**Question 1 & 2:** If the form is submitted to the MA PFML insurance carrier prior to the birth of a child, this is considered pre-submitting. The employee is then required to provide the required documentation of the child's birth to the MA PFML insurance carrier. The MA PFML carrier will tell the employee how to provide the required additional documentation.

There may be instances where MA PFML can be taken before the adoption or foster care is finalized. For example, the employee may be required to appear in court or travel to another country as part of the adoption or foster care process. The employee should include documentation to show that the MA PFML is necessary to further the adoption or foster care.

**Question 5:** See chart below for documentation details. Unless specified, do not send the original documents.

<b>Bonding Form/Certification</b>	<b>Description</b>
Health care provider certification of pregnancy	An <b>original</b> letter obtained from the birth mother's health care provider that certifies pregnancy. It should include the mother's name and the expected due date.
Health care provider certification of birth	An <b>original</b> letter obtained from the birth mother's health care provider that includes the mother's name and child's date of birth.
Birth Certificate	A <b>copy</b> of the certificate issued by the city or county office in which the child is born.
Voluntary Acknowledgment of Paternity	A <b>copy</b> of the form that establishes legal fatherhood when the parents are unmarried. Completed by both mother and father.
Court Order	<b>Documentation</b> of the order from the family court that names the father of a child. Establishes legal fatherhood when the parents are unmarried. Completed by both mother and father.
Marriage Certificate	A <b>copy</b> of the official statement issued by the town or city clerk from which the marriage certificate was issued.
Civil union/domestic partner's documentation	A <b>copy</b> of the certificate of civil union or domestic partnership.
Foster care placement letter	A <b>copy</b> of the letter of foster care placement issued by the county or city department of social services or authorized voluntary foster care agency.
Court documents of adoption	A <b>copy</b> of the court document finalizing adoption or documentation in furtherance or court order finalizing adoption.
Other documentation	Other documentation of parental relationship may be accepted if none of the others listed apply.

**TO BE COMPLETED BY THE EMPLOYEE**

Employee's legal name (first name, middle initial, last name)		Employee's date of birth (MM/DD/YYYY)	
Other last names, if any, under which employee has worked		Employee's Social Security Number or TIN	
Employee's mailing address Street			
City	State	Zip Code	Country (if not U.S.A.)

**BONDING CERTIFICATION (to be completed by the employee)**

1. Child's date of birth (MM/DD/YYYY)	2. Child's gender <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Not designated/Other	3. Does child live with the employee requesting MA PFML? <input type="checkbox"/> Yes <input type="checkbox"/> No
4. Child is employee's: <input type="checkbox"/> Biological child <input type="checkbox"/> Stepchild <input type="checkbox"/> Foster child <input type="checkbox"/> Adopted child <input type="checkbox"/> Legal ward <input type="checkbox"/> <i>in loco parentis</i> child <input type="checkbox"/> Former minor child <i>in loco parentis</i> <input type="checkbox"/> Spouse/Domestic partner's child		
5. Select one of the following and attach the document as required as evidence of the relationship. <b>Parent of newborn child:</b> <b>Birth mother</b> <input type="checkbox"/> Health care provider certification of pregnancy (include expected due date AND mother's name); OR <input type="checkbox"/> Health care provider certification of birth (include date of birth of child AND mother's name); OR <input type="checkbox"/> Child's birth certificate <b>Other parent</b> <input type="checkbox"/> Copy of birth certificate naming second parent; OR <input type="checkbox"/> Voluntary acknowledgment of paternity; OR <input type="checkbox"/> Court order of Paternity; OR <input type="checkbox"/> Birth mother documents (see above) PLUS one of the following: <input type="checkbox"/> Marriage certificate; OR <input type="checkbox"/> Certificate of civil union; OR <input type="checkbox"/> Evidence of domestic partnership <input type="checkbox"/> OR; Other documentation of parental relationship <b>Foster parent</b> <input type="checkbox"/> Letter of foster care placement or anticipated placement issued by county or city department of Social Services or authorized voluntary foster care agency <b>Adoptive parent</b> <input type="checkbox"/> Court document finalizing adoption <input type="checkbox"/> Documentation in furtherance of adoption		
6. Date of foster care or adoption placement, if applicable (MM/DD/YYYY)		
<b>Declaration and signature</b> 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. 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)