



# TheStandard®

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: Bond with a newborn, a newly adopted or fostered child

**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-2**

- Complete 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 5 days once a complete claim is received.

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

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

### **Connecticut Paid Family And Medical Leave (CT PFML) Request (to be completed by the employee)**

**Question 10: Family member** means an employee's spouse, sibling, son or daughter, grandparent, grandchild, parent (includes parent-in-law), or an individual related to the employee by blood or affinity whose close association the employee shows to be the equivalent of those family relationship.

**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, parent-in-law, adoptive, step-brother or step-sister of the employee.

**Spouse** means a husband or wife or domestic partner of an employee.

**Family Member Equivalent:** an individual related to the employee by blood or affinity whose close association the employee shows to be the equivalent of those family relationship.

**Question 11:** If dates are "Continuous", the employee must provide the start and end dates of the requested CT PFML. These dates should be the actual dates that the CT 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 CT 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 CT PFML day is taken. Payment for approved claims will be due 15 calendar days from the date of the claim decision.

**Question 12:** Date employer was notified. If the employee is submitting the CT PFML request to their employer with less than 30 days' advance notice from the start date of the CT 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 CT 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 CT 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. **Payment for approved claims will be due 15 calendar days from the date of the claim decision.**

If The Standard does not permit pre-submitting, The Standard must return the Request for Connecticut 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 CT 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.

“Wage” or “wages”: For the purpose of payment of benefits, means a Covered Employee’s remuneration from the Employer for employment and dismissal payments.

Weekly Wages: means an amount equal to one twenty sixth, rounded to the next lower dollar, of a Covered Employee’s Total Wages, as defined in subsection (b) of Section 31-222 of the general statutes, or self-employment income, as defined in 26 USC 1402(b), as amended from time to time, earned during the two quarters of the Covered Employee’s base period in which such earnings were highest.

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

**Be sure to complete the appropriate additional CT PFML form(s) based on the type of CT 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
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 CT PFML (if available)		8. Employee's gender <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Not designated/Other	
9. Reason for CT PFML request: <input type="checkbox"/> Bond with child <input type="checkbox"/> Adoption/Foster child <input type="checkbox"/> Care for family member <input type="checkbox"/> Employee Impacted by Family Violence <input type="checkbox"/> Military qualifying event <input type="checkbox"/> Military Caregiver: Care of a family member injured in the line of duty <input type="checkbox"/> Own serious health condition due to Covered Employee serving as a Bone Marrow Donor <input type="checkbox"/> Own serious health condition due to Covered Employee serving as an Organ Donor <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 or registered domestic partner <input type="checkbox"/> Sibling <input type="checkbox"/> Parents and legal guardians (or spouse's parent)		<input type="checkbox"/> Family Member Equivalent <input type="checkbox"/> Grandparent <input type="checkbox"/> Grandchild	
11. Will CT PFML be for a continuous period of time and/or periodic? <input type="checkbox"/> Continuous _____ / _____ / _____ CT PFML start date (MM/DD/YYYY) _____ / _____ / _____ CT PFML end date (MM/DD/YYYY) <input type="checkbox"/> Dates are estimated			
Identify dates periodic CT PFML will be taken: <input type="checkbox"/> Periodic _____ <input type="checkbox"/> 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)	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
17. Employer's telephone number for contact regarding this request. ( )	18. Is employee currently receiving Workers' Compensation Benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No	
19. List income you will be receiving while on CT PFML, source of pay and amount.		
20. Have you taken any leave in the last 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No	21. If yes list dates and type of leave.	

**Disclosure statement:** Information regarding CT PFML benefits received by the employee, such as payments received and types of leave, will be provided to the employer.

## Declaration and signature

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.

Employee's signature	Date signed (MM/DD/YYYY)
<input type="checkbox"/> 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

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PO Box 3877 Portland OR 97208

**Request For  
Connecticut Paid Family And Medical Leave  
(Form CT 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)
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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 CT 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 Weekly Wages			
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.			
12. Will any full days of accrued paid time* be used in place of PFML benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, please provide dates where full days of accrued paid time is being used. _____ <i>*Accrued paid time could be sick leave, annual leave, vacation leave, personal leave, compensatory leave or paid time off. Use of full days of accrued paid time, in place of PFML benefits, will not decrement the employee's PFML bank.</i>			
13a. What type of paid benefits will the employee receive while on CT PFML? Include the last date through which any compensation will be paid.			
13b. Is the leave request a result of employee's injury on the job? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, has the employee applied for Worker's Compensation payments/benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, has the employee received Worker's Compensation payments/benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No Amount of Weekly Payment/Benefit: _____ Effective date of benefits: _____			
14. CT PFML policy number			
CT 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 Connecticut Paid Family And Medical Leave. 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.			
Employer's authorized signature	Date signed (MM/DD/YYYY)		
Title			

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

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

*The employee requesting 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 PFML insurance carrier prior to the birth of a child, this is considered presubmitting. The employee is then required to provide the required documentation of the child's birth to the PFML insurance carrier. The PFML carrier will tell the employee how to provide the required additional documentation.

There may be instances where 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 PFML is necessary to further the adoption or foster care.

**Question 5:** If dates are "Continuous", the employee must provide the start and end dates of the requested PFML. These dates should be the actual dates that the 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 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 PFML. If uncertain, estimate the frequency of leave and indicate "Dates are estimated".

**Question 6:** See chart below for documentation details. Unless specified, do not send the original documents.

Bonding Form/Certification	Description
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 of Paternity	<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 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"/> Spouse/Domestic partner's child		
5. Will 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		
6. 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		

7. Date of foster care or adoption placement, if applicable (MM/DD/YYYY)

**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 4 of this form.

Employee's signature

Date signed (MM/DD/YYYY)

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

The tax obligations for receipt of Connecticut 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 CT PFML benefit. You can have both Federal and Connecticut State tax withheld from your Paid Family and Medical Leave Benefits. Taxes will be withheld after deductions are taken.

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