



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: 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 Oregon Paid Family And Medical Leave (OR PFML), the employee requesting OR PFML must complete Part A of the *Request For Oregon Paid Family And Medical Leave (Form OR 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 Oregon Paid Family And Medical Leave (Form OR 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 Oregon Paid Family And Medical Leave (Form OR PFML-1)* with the required additional form(s) 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 OR PFML must complete all required information.***Oregon Paid Family And Medical Leave (OR PFML) Request (to be completed by the employee)****Question 9: Bond with child** means to care for and bond with a Child during the first year after the Child's birth.**Adoption/Foster child** means to care for and bond with a Child during the first year after the placement of the Child through Foster Care or adoption.**Care for Family Member with a Serious Health Condition** means Physical Assistance or Psychological Assistance as used for leave taken to care for a Family Member with a Serious Health Condition.**Safe Leave** means leave for any purpose described in ORS 659A.272, including leave to:

- Seek legal or law enforcement assistance or remedies to ensure the health and safety of the Eligible Employee or the Eligible Employee's minor Child or dependent, including preparing for and participating in protective order proceedings or other civil or criminal legal proceedings related to Domestic Violence, Harassment, Sexual Assault or Stalking.
- Seek medical treatment for or to recover from injuries caused by Domestic Violence or Sexual Assault to or Harassment or Stalking of the Eligible Employee or the Eligible Employee's minor Child or dependent.
- Obtain, or to assist a minor Child or dependent in obtaining, counseling from a licensed mental health professional related to an experience of Domestic Violence, Harassment, Sexual Assault or Stalking.
- Obtain services from a victim services provider for the Eligible Employee or the Eligible Employee's minor Child or dependent.
- Relocate or take steps to secure an existing home to ensure the health and safety of the Eligible Employee or the Eligible Employee's minor Child or dependent.
- An Employee applying for PFML Benefits for Safe Leave must provide verification of the basis for the Safe Leave, including any of the following forms of documentation: (a) A copy of a federal agency or state, local, or tribal police report, or a formal complaint to a school's Title IX Coordinator indicating that the Claimant or the Claimant's Child was a victim of Domestic Violence, Harassment, Sexual Assault, or Stalking; (b) A copy of a protective order or other evidence from a federal, state, local, or tribal court, administrative agency, school's Title IX Coordinator, or attorney that the claimant or the Claimant's Child appeared in or was preparing for a civil, criminal, or administrative proceeding related to Domestic Violence, Harassment, Sexual Assault, or Stalking; or (c) Documentation from an attorney, law enforcement officer, Health Care Provider, licensed mental health professional or counselor, member of the clergy, or victim services provider that the claimant or the Claimant's Child was undergoing treatment or counseling, obtaining services, or relocating as a result of Domestic Violence, Harassment, Sexual Assault, or Stalking; or

In cases where a Claimant can demonstrate Good Cause for not providing one of the forms of documentation in section (i), the claimant may instead provide a written statement attesting that they are taking eligible Safe Leave. Good Cause for not providing the documentation is determined at our discretion and includes, but is not limited to, the following:

- (A) Difficulty obtaining verification due to a lack of access to services; or
- (B) Concerns for the safety of the Claimant or the Claimant's Child.

Own Serious Health Condition due to Covered Employee serving as a Bone Marrow Donor**Own Serious Health Condition** due to Covered Employee serving as an Organ Donor**Own Serious Health Condition due to pregnancy** means any period of disability due to pregnancy, childbirth, miscarriage or stillbirth, or period of absence for prenatal care.**Own Serious Health Condition (other)** means an illness, injury, impairment, or physical or mental condition of an Eligible Employee.

Oregon Paid Family And Medical Leave (OR PFML) Request (to be completed by the employee) continued

Question 10: Family Member means an employee's spouse, sibling, child, grandparent, grandchild, parent or an individual related to the employee by blood or affinity whose close association with an eligible employee is the equivalent of a family relationship.

Sibling means the Eligible Employee's, or the Eligible Employee's Spouse's or Domestic Partner's, sibling or stepsiblings.

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 an Eligible Employee's, or an Eligible Employee's Spouse's or Domestic Partner's, child of the Child.

Grandparent means an Eligible Employee's, or an Eligible Employee's Spouse's or Domestic Partner's, parent of the Parent.

Parent means (a) the biological, adoptive, step or foster mother or father of the Eligible Employee; (b) a person who was a foster parent of an Eligible Employee when the Eligible Employee was a minor; (c) a person designated as the legal guardian of an Eligible Employee at the time the Eligible Employee was a minor or required a legal guardian; (d) a person with whom an Eligible Employee was or is in a relationship of in loco parentis; or (e) a parent of an Eligible Employee's Spouse or Domestic Partner.

Spouse means a person to whom an Eligible Employee is legally married.

Family Member equivalent means an individual related to the employee by blood or affinity whose close association with an eligible employee is the equivalent of a family relationship.

Affinity means a relationship that meets the following requirements:

There is a significant personal bond that is like a family relationship, and;

The relationship has characteristics of a family relationship, which may include, but is not limited to the following:

- (A) Shared personal financial responsibility, including shared leases, common ownership of real or personal property, joint liability for bills, or beneficiary designations;
- (B) Emergency contact designations;
- (C) The expectation to provide care because of the relationship or the prior provision of care;
- (D) Cohabitation; and
- (E) Geographical proximity.

Question 11: If dates are "Consecutive", the employee must provide the start and end dates of the requested OR PFML. These dates should be the actual dates that the OR 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 OR PFML will be taken. Please be as specific as possible. If the dates are unknown or estimated, indicate "Dates are estimated".

Intermittent Leave means leave taken in separate periods of time due to a single Qualifying Reason, rather than for one continuous period of time. Intermittent leave shall be taken in increments of no less than one Work Day and will be paid in increments that are equivalent to one Work Week.

If dates are estimated, The Standard may require you to submit a request for payment after the OR PFML day is taken. Payment for approved claims will be due 7 calendar days from the date of the claim decision.

Exclusions: PFML benefits will not be payable if the employee would not be performing their employment duties for reasons including but not limited to circumstances related to:

- (a) An employer's business operations, such as: a lapse in seasonal operations; school break periods; or other suspensions or cessations of an employer's business operations.
- (b) A period of incarceration, in which an individual is unable to perform their employment duties as a result of being an adult in custody.

Question 12: The Claimant must provide written notice to the Employer at least 30 calendar days in advance of foreseeable PFML. Verbal notice by the Claimant or a Family Member must be provided to the Employer within 24 hours of unforeseeable leave. In the context of Safe Leave, if it is not possible to provide notice in these timeframes, notice should be provided as soon as practicable. If the explanation will not fit in the space provided, 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 21: List all other income you will be receiving while on OR PFML. Include the type/name of income and how much. Example Employer Sponsored Paid leave for \$500.00 a week.

If you are pre-submitting form: Indicate if the employee is pre-submitting their OR 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 7 calendar days from the date of the claim decision.** If a Complete Application is approved more than 7 calendar days before the onset of PFML, we will commence payment of PFML Benefits as soon as PFML begins.

If The Standard does not permit pre-submitting, The Standard must return the Request for Oregon 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 OR 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 8a: Indicate number of hours the employee typically works per week. Example: 20, 32, or 40.

Question 9: PFML benefits will not be payable for any period of a week or longer that the Eligible Employee is not expected to be available to work or able to work for the Employer based on circumstances related to the Employer's business, including but not limited to:

- a. A lapse in seasonal operations
- b. School breaks
- c. Other suspensions or cessations of an Employer's business operations.

During an Eligible Employee's period of incarceration, in which they are unable to perform their employment duties for the Employer as a result of being an adult in custody.

Question 10a: "Wage" or "wages": For the purpose of payment of benefits, means a Covered Employee's remuneration from the Employer for employment and dismissal payments. May include variable pay in addition to their usual earnings, such as overtime pay, extended work hours (not necessarily OT), bonus pay, commissions and the like during the last 12 months.

Average Weekly Wage means the Eligible Employee's weekly Subject Wages in effect with the Employer on the day immediately preceding the date PFML begins. For Eligible Employees 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. If the Eligible Employee 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). If an Eligible Employee is paid on an annual contract basis, the Average Weekly Wage is based on one-fifty-second (1/52nd) of the Eligible Employee's annual contract salary with the Employer. If an Eligible Employee has multiple Employers, the Average Weekly Wage will be calculated for each employer separately.

Question 10b: An example of employees not subject to Social security and/or Medicare are certain public employees contributing to their own program and student employees of colleges and universities.

Question 11a-b: OR PFML employer reimbursement is only permitted for Wage continuation, including a paid family and/or medical leave policy of the employer. Wage continuation is an employer's continued payment of an employee's wages during a period of PFML leave. Accrued Paid Leave is not wage continuation.

The Employer is not eligible for reimbursement for Accrued Paid Leave paid to the Eligible Employee.

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

Be sure to complete the appropriate additional OR PFML form(s) based on the type of OR 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 OR PFML (if available)				8. Employee's gender <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Not designated/Other		
9. Reason for OR PFML request: Bonding: <input type="checkbox"/> New child <input type="checkbox"/> Adoption/Foster child <input type="checkbox"/> Care for Family Member with a Serious Health Condition <input type="checkbox"/> Safe Leave <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"/> Family Member equivalent <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 OR PFML be for a continuous period of time and/or Intermittent? <input type="checkbox"/> Consecutive _____ / _____ / _____ OR PFML start date (MM/DD/YYYY) _____ / _____ / _____ OR PFML end date (MM/DD/YYYY) <input type="checkbox"/> Dates are estimated Identify dates Intermittent OR PFML will be taken: <input type="checkbox"/> Intermittent _____ <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	Country (if not U.S.A.)
17. Employer's telephone number for contact regarding this request. ()		18. Is employee receiving Workers' Compensation Benefits, Unemployment Benefits, or income from any other sources? <input type="checkbox"/> Yes <input type="checkbox"/> No			
19. Have you had a decrease in wages in the last 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, was it with your current employer? <input type="checkbox"/> Yes <input type="checkbox"/> No					
20. List all other employment or Employers in last 12 months:					
21. List income you will be receiving while on OR PFML, source of pay and amount.					
22. Have you taken any leave in the last 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No		23. If yes list dates and type of leave:			

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

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.

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 OR 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 physically at work (MM/DD/YYYY)		
8a. Employee's Typical Work Week Hours			
8b. 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			
8c. If Employee's Work Hours are rotating, indicate hours and rotation			
9. List the dates of any period a week or longer that the employee is not expected to be available to work or able to work while on PFML leave due to a lapse in seasonal operations, school breaks, or other suspensions or cessations of business operations. (example: December 18 - January 1 and March 25 - March 31 or N/A if not applicable). <i>*PFML benefits will not be payable for any period of incarceration in which an individual is unable to perform their employment duties as a result of being an adult in custody. List all dates, if known.</i>			
10a. Employee's Average Weekly Wage: _____			
10b. 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			
10c. Has employee met the annual limit to Social Security max. contribution? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A			
11a. Will any full days of Wage continuation, including the employer's own internal paid family and/or medical leave policy, be used by or paid to the employee in place of OR PFML benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, please provide dates where full days of Wage Continuation are being paid within question 14 (Additional information). <i>*Wage continuation is an employer's continued payment of an employee's regular salaried wages during a period of PFML leave. Accrued Paid Leave, which includes sick leave, Oregon Paid Sick Leave, annual leave, vacation leave, personal leave, compensatory leave or paid time off is not Wage continuation. The Employer is not eligible for reimbursement of PFML benefits for Accrued Paid Leave paid to the Eligible Employee.</i>			
11b. If employee received or will receive full wages while on OR PFML, will employer be requesting reimbursement of the PFML benefit amounts? <input type="checkbox"/> Yes <input type="checkbox"/> No			
12. Is the employee receiving Workers' Compensation Benefits or Unemployment Benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No Effective date of benefits: _____			
13. OR PFML policy number			
14. Additional 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) (Continued)

OR PFML insurance carrier's name and mailing address Standard Insurance Company PO Box 3877 Portland, OR 97208 866-751-5174 Fax	
Declaration and signature <input type="checkbox"/> I affirm the employee meets the eligibility for Oregon Paid Family And Medical Leave. 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. My signature affirms that the information I am providing is true and accurate to the best of my knowledge and belief.	
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 original 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 original 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 copy of the certificate issued by the city or county office in which the child is born.
Voluntary Acknowledgment of Paternity	A copy of the form that establishes legal fatherhood when the parents are unmarried. Completed by both mother and father.
Court Order of Paternity	Documentation 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 copy 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 copy of the certificate of civil union or domestic partnership.
Foster care placement letter	A copy 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 copy 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. Parent of newborn child: Birth mother <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 Other parent <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 Foster parent <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 Adoptive parent <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)

Paid Family And Medical Leave Claim Form Fraud Notices

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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PO Box 3877 Portland OR 97208

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

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

- Withholding Federal and/or Oregon State Tax is voluntary. 10% of your benefits would be withheld for Federal taxes and 8% would be withheld for Oregon State taxes.
 - If you do not have Federal and/or Oregon State income tax withheld, you may need to make estimated quarterly tax payments.
- The Federal and Oregon 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 8% Oregon 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"/> Start withholding 10% Federal Income Tax.	<input type="checkbox"/> Start withholding 8% ORS Income Tax.
<input type="checkbox"/> Stop withholding 10% Federal Income Tax.	<input type="checkbox"/> Stop withholding 8% ORS 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.