TheStandard®

Reset

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:
Care for a family member with a serious health condition

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-3
- ☐ Care recipient completes PFML-3 and provides to Health Care Provider
- ☐ Care recipient's Health Care Provider keeps PFML-3

Complete Form PFML-4
- ☐ Complete "Employee" information at the top of PFML-4
- ☐ Provide PFML-4 to care recipient's Health Care Provider
- ☐ Care recipient's Health Care Provider completes PFML-4 and returns to you

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 Minnesota Paid Family And Medical Leave (Form MN PFML-1) Instructions

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

Minnesota Paid Family And Medical Leave (MN PFML) Request (to be completed by the employee)

Question 9: Bonding Leave means PFML taken within 12 months after a Child's birth, adoption or placement of a foster child, except that, in the case where the Child must remain in the hospital longer than the birth parent, the PFML must end within 12 months after the Child leaves the hospital. Bonding leave also includes PFML taken before the actual placement or adoption of a Child in situations that include but are not limited to where the Employee may be required to:

1. attend counseling sessions;
2. appear in court;
3. consult with the attorney or doctors representing the birth parent;
4. submit to a physical examination; or
5. travel to another country to complete an adoption.

Family Care Leave means PFML taken by an Applicant to care for a Family Member with a Serious Health Condition or to care for a Family Member who is a Military Member.

Safe leave means PFML from work because of domestic abuse, sexual assault, or stalking of the Applicant or Applicant's Family Member, provided the PFML is to:

1. seek medical attention related to the physical or psychological injury or disability caused by domestic abuse, sexual assault, or stalking;
2. obtain services from a victim services organization;
3. obtain psychological or other counseling;
4. seek relocation due to the domestic abuse, sexual assault, or stalking; or
5. seek legal advice or take legal action, including preparing for or participating in any civil or criminal legal proceeding related to, or resulting from, the domestic abuse, sexual assault, or stalking.

Qualifying Exigency means a need arising out of a Military Member's active duty service or notice of an impending call or order to active duty in the United States armed forces, including providing for the care or other needs of the Family Member's child or other dependent, making financial or legal arrangements for the Family Member, attending counseling, attending military events or ceremonies, spending time with the Family Member during a rest and recuperation leave or following return from deployment, or making arrangements following the death of the Military Member.

Medical Care Related to Pregnancy means prenatal care or Incapacity due to pregnancy or recovery from childbirth, stillbirth, miscarriage, or related health conditions.

Medical Leave means PFML taken by an Applicant that is made necessary by the Applicant's own Serious Health Condition which renders them unable to work.

Question 10: Family Member means the Applicant's: spouse or Domestic Partner; Child; Parent; sibling; Grandchild; Grandparent; son-in-law or daughter-in-law; and an individual who has a personal relationship with the Applicant that creates an expectation and reliance that the Applicant care for the individual without compensation, whether or not the Applicant and the individual reside together.

Child means means an Applicant's child, including a biological child, adopted child, foster child, stepchild, child of a domestic partner, or child to whom the Applicant stands In Loco Parentis, is a legal guardian, or is a de facto custodian.

Grandchild means the Applicant's, the Applicant's spouse's or the Applicant's Domestic Partner's child of a Child.

Grandparent means the Applicant's, the Applicant's spouse's or the Applicant's Domestic Partner's parent of a Parent.

Parent means the Applicant's, the Applicant's spouse's, or the Applicant's Domestic Partner's biological, adoptive, de facto custodian, or foster parent, stepparent, or legal guardian, or an individual who stood In Loco Parentis to an Applicant when the Applicant was a child.

Question 11: If dates are "Continuous", the employee must provide the start and end dates of the requested MN PFML. These dates should be the actual dates that the MN 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 MN 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 MN PFML. If uncertain, estimate the frequency of leave and indicate "Dates are estimated".

Question 12: Date employer was notified. If the employee is submitting the MN PFML request to their employer with less than 30 days' advance notice from the start date of the MN 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.

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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 MN PFML. Include the type/name of income and how much. Example PTO from employer for $500.00 a week.

Payment for approved claims will be due 14 calendar days from the date of the claim decision.

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

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

The employer of the employee requesting MN PFML must complete all information in Part B.

Question 2: If a Social Security Number is used for the Federal Employer Identification Number (FEIN), enter the Social Security Number.

Question 8: Wages means compensation for an Employee's employment with the Employer under Minn. Stat. §268.035, subdivision 29.

Wage Credits means the amount of Wages Paid within an Applicant's Base Period for Covered Employment.

Average Weekly Wage means an amount equal to the Applicant's high quarter Wage Credits divided by 13. [For Applicants that have changed employers within the Base Period, the average weekly wage is calculated based on the highest quarter of Wages in the Base Period.]

Base Period means the most recent four quarters in which Wage Credits were earned with the Employer as provided by the Employer. If an Employer does not have four quarters of wage detail information, the Employer must accept an Employee's certification of wage credits, based on the Employee's records. If the Employee does not provide certification of additional wage credits, the Employer may use a base period that consists of all available quarters. The base period is calculated once during the Benefit Year.

Typical Workweek means the average number of hours worked per week by an Employee within the last two quarters prior to the Effective Date of Application**.**

Question 11: Wage Continuation is an employer's continued payment of an employee's regular salaried wages during a period of PFML leave.

Question 12: To qualify for reimbursement from us, the Employer must pay Wage continuation to the Covered Individual that is equal to or greater than the Weekly Benefit Amount.

The Employer is not eligible for reimbursement of vacation, sick pay, paid time off or disability insurance paid to the Applicant.

Question 13: No PFML Benefits are payable for any portion of a typical work week for which the Applicant is receiving or has received Minnesota unemployment insurance benefits**.**

Affirmation employee is eligible for MN PFML:

To be eligible for any family and medical leave, an employee must be a Covered Employee and have wage credits of at least 5.3 percent of the state's average annual wage rounded down to the next lower $100.

"Covered employment" means performing services of whatever nature, unlimited by the relationship of master and servant as known to the common law, or any other legal relationship performed for wages or under any contract calling for the performance of services, written or oral, express or implied.

Covered employment means an employee's entire employment during a calendar year if:

(1) 50 percent or more of the employment during the calendar year is performed in Minnesota; or

(2) 50 percent or more of the employment during the calendar year is not performed in Minnesota or any other single state within the United States, or United States territory or foreign nation, but some of the employment is performed in Minnesota and the employee's residence is in Minnesota during 50 percent or more of the calendar year.

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

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

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

9. Reason for MN PFML request:
Bonding Leave: ☐ New child ☐ Adoption/Foster child
☐ Care for Family Member with a Serious Health Condition ☐ Safe Leave ☐ Qualifying Military Exigency
☐ Own Serious Health Condition due to pregnancy ☐ Own Serious Health Condition (other)

10. The family member is employee's: ☐ Child ☐ Spouse ☐ Sibling ☐ Parent ☐ Grandparent ☐ Grandchild ☐ Son-in-law or Daughter-in-law
☐ Individual who has a personal relationship with the Applicant that creates an expectation and reliance that the Applicant care for the individual without compensation, whether or not the Applicant and the individual reside together.

11. Will MN PFML be used for a Continuous period of time, Intermittently and/or on a Reduced Leave Schedule?
☐ Continuous _____ / _____ / _____ _____ / _____ / _____ ☐ Dates are estimated
start date (MM/DD/YYYY) end date (MM/DD/YYYY)

☐ Intermittent (separate, non-consecutive time)
Days/hours(s) requested: _____ ☐ Dates are estimated

☐ Reduced Leave Schedule (consistent but reduced work schedule for multiple weeks)
Days/hours(s) requested: _____ ☐ Dates are estimated
(example: 2 days per week, or 4 hours per day, or every Monday)

Employment Information (to be completed by the employee)

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

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

15. Has your employment ended? If so, what was your termination date?

16. Employee's work location Street address

City	State	Zip code	Country (if not U.S.A.)

17. Employer's telephone number for contact regarding this request. ( )	18. Are you receiving Workers' Compensation, Unemployment Insurance Benefits or Social Security disability benefits? ☐ Yes ☐ No

19. List income or financial benefits you will be receiving while on MN PFML, source of pay and amount.

20. Have you had a decrease in wages during the last 12 months? ☐ Yes ☐ No
If yes, was it with your current Employer? ☐ Yes ☐ No

21. Have you taken any leave in the last 12 months? ☐ Yes ☐ No	22. If yes list dates and type of leave.

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

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Request For Minnesota Paid Family And Medical Leave (Form MN 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)

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.

Employee's signature	Date signed (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 MN PFML

5. Employer's contact telephone number ( )	6. Employer's contact email address

7a. Employee's date of hire (MM/DD/YYYY)	7b. Employee's last day of work (MM/DD/YYYY)

8a. Employee's Average Weekly Wage _____
8b. Is employee subject to Social Security taxes? ☐ Yes ☐ No Medicare taxes? ☐ Yes ☐ No
8c. Has employee met the annual limit to Social Security max. contribution? ☐ Yes ☐ No ☐ N/A

9. Check Days Normally Worked ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday ☐ Sunday
Indicate Hours Normally Worked _____ _____ _____ _____ _____ _____ _____

10. List the dates of any period a week or longer that the employee is not scheduled or able to work due to lapses in seasonal operations, school breaks, or other suspensions or cessations of business operations while on PFML leave, including federal, state, local or Employer designated holidays: (example: December 18 - January 1 and March 25 - March 31 or N/A if not applicable)

_____

11. Will Wage continuation be paid to the Covered Individual that is equal to or greater than the Weekly Benefit Amount? ☐ Yes ☐ No
If yes, provide dates: _____

12. If employee received or will receive wage continuation while on MN PFML, will employer be requesting reimbursement? ☐ Yes ☐ No
If yes, provide dates: _____

13. Has the employee filed for Workers' Compensation Benefits or Unemployment Benefits? ☐ Yes ☐ No
If yes, provide benefit dates: _____

14. Has the employee received, or eligible to receive, severance pay? ☐ Yes ☐ No
If yes, provide benefit amount: _____

15. MN PFML policy number

MN 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 requirements for Minnesota Paid Family and Medical Leave.

I am the person authorized to sign as the employer of the employee requesting MN 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
Release Of Personal Health Information
For Family Member
(Form PFML-3)

- If an employee is requesting Paid Family And Medical Leave (PFML) to care for a family member with a serious health condition, the family member or an authorized representative must complete a *Release Of Personal Health Information For Family Member* (Form PFML-3) and submit it to their Health Care Provider, along with a copy of the *Certification For Care Of Family Member* (Form PFML-4).
- The *Release Of Personal Health Information For Family Member* (Form PFML-3) enables the Health Care Provider to complete *Certification For Care Of Family Member* (Form PFML-4) and release it to the employee seeking PFML benefits.
- Before completing and signing, the family member must read the *Release Of Personal Health Information For Family Member* (Form PFML-3) in its entirety.
- The employee requesting PFML submits both the *Request For Paid Family And Medical Leave* (Form PFML-1) and the *Certification For Care Of Family Member* (Form PFML-4) to their employer's PFML insurance carrier, for PFML benefit determination.

NOTE: This form will be retained by the Health Care Provider. The employee should make a copy for their records before giving it to the Health Care Provider.

Family member or authorized representative signs and dates.

RELEASE OF PERSONAL HEALTH INFORMATION BY THE HEALTH CARE PROVIDER FOR A FAMILY MEMBER WITH A SERIOUS HEALTH CONDITION (to be completed by the family member or authorized representative and submitted to family member's Health Care Provider with Form PFML-4)

Employee enters their name, and family member's name and date of birth at the top of each page.

The PFML insurance carrier name requested at the top of the form is the same as the PFML insurance carrier identified in *Request For Paid Family And Medical Leave* (Form PFML-1) Part B line 13.

Family member or authorized representative must complete all applicable requested information.

If a family member is unable to fill out this form, an authorized representative must attach a copy of legal documentation, such as a health care proxy or power of attorney, permitting the representative to sign on behalf of the family member. The Health Care Provider will require this documentation of authorization unless the authorized representative is a parent signing on behalf of a minor child.

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Paid Family And Medical Leave
Release Of Personal Health Information
For Family Member
(Form PFML-3)

TO BE COMPLETED BY THE EMPLOYEE

Employee's legal name (first name, middle initial, last name)	
Family member's legal name	Family member's date of birth (MM/DD/YYYY))
Relationship of family member to employee	

RELEASE OF PERSONAL HEALTH INFORMATION BY THE HEALTH CARE PROVIDER FOR A FAMILY MEMBER WITH A SERIOUS HEALTH CONDITION (to be completed by the family member or authorized representative and submitted to family member's Health Care Provider with Form PFML-4)

I, _____ , authorize my Health Care Provider listed on this form to
Family member's legal name

release my personal health information to _____ and Standard Insurance Company.
Employee's legal name

Records Subject to Release: This form gives the Health Care Provider listed permission to include information from your health care records on the attached medical certification. This form gives your Health Care Provider permission to release only the information in your health care records that relate to your current condition, which is the subject of the employee's request for Paid Family And Medical Leave benefits.

Duration of Revocable Release: This authorization ends after one year, or when you revoke the release. You can cancel this release at any time. To cancel, send a letter to the Health Care Provider listed on this form.

This form does NOT allow your Health Care Provider to release the following types of information, unless you specifically permit such release. Put an "X" next to any information your health provider MAY release:

☐ HIV/AIDS related information ☐ Mental health information ☐ Alcohol/drug treatment ☐ Psychotherapy notes

Health Care Provider Information (to be completed by the family member or authorized representative)

Identify the Health Care Provider who is currently providing you with treatment for a condition that is subject to the employee's request for PFML benefits.

1. Health Care Provider's name			
2. Health Care Provider's mailing address			
City	State	Zip Code	Country (if not U.S.A.)
3. Health Care Provider's telephone number (provide area or country code) ( )			

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Paid Family And Medical Leave
Release Of Personal Health Information
For Family Member
(Form PFML-3)

TO BE COMPLETED BY THE EMPLOYEE

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

RELEASE OF PERSONAL HEALTH INFORMATION BY THE HEALTH CARE PROVIDER FOR A FAMILY MEMBER WITH A SERIOUS HEALTH CONDITION (to be completed by the family member or authorized representative and submitted to family member's Health Care Provider with Form PFML-4)

Family member Information (to be completed by the family member or authorized representative)

4. Family member's mailing address			
City	State	Zip Code	Country (if not U.S.A.)
5. Family member's Social Security Number		6. Family member's telephone number (provide area or country code) ( )	

READ AND SIGN BELOW

I have a serious health condition and thereby request that the Health Care Provider listed give a completed *Health Care Provider Certification For Care Of Family Member With Serious Health Condition* (Form PFML-4) to the employee identified on Form PFML-4, I understand that such information includes a diagnosis and prognosis of my current condition, the date it commenced, and any estimation of the amount of care that I require from the employee requesting PFML benefits as a result of my current condition.

Family member's signature	Date signed (MM/DD/YYYY)

Authorized representative

I, _____ , represent the family member in this matter as authorized by:
Print legal name

☐ Parental right ☐ Power of attorney (attach copy) ☐ Court order (attach copy) ☐ Health care proxy (attach copy)

Authorized representative's signature	Date signed (MM/DD/YYYY)

The employee should retain a copy for their own records.

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Paid Family And Medical Leave Certification For Care Of Family Member (Form PFML-4) Instructions

To Be Completed by Employee

INSTRUCTION to the EMPLOYEE: **The employee requesting Paid Family And Medical Leave (PFML) to care for family member with a serious health condition must submit the *Certification For Care Of Family Member* (Form PFML-4) with *Request For Paid Family and Medical Leave* (Form PFML-1). Fill out the employee information of this form and give to the Health Care Provider along with *Release Of Personal Health Information For Family Member* (Form PFML-3). When you receive the completed *Certification For Care Of Family Member* (Form PFML-4) from the Health Care Provider, send the completed forms and supporting documentation to The Standard.**

Employee's Name				
Employee's Address	City	State	ZIP	Phone No.
Family member's Name	Relationship of family member to employee	Family member date of birth		
Family member's Address	City	State	ZIP	Phone No.

To Be Completed By Health Care Provider

INSTRUCTIONS for HEALTH CARE PROVIDERS

This form is used to certify a serious health condition in order to qualify for Paid Family and Medical Leave (PFML). Answer each question to the best of your medical knowledge, based on your examination of the patient.

PART A: MEDICAL FACTS

1. Diagnosis _____ Primary ICD Code *(optional)* _____

   Approximate date condition commenced: _____ Probable duration of condition: _____

   Was the family member admitted for an overnight stay in a hospital, hospice, or residential medical care facility? ☐ Yes ☐ No

   If so, dates of admission: _____

   _____

   Date(s) you treated the family member for condition: _____

   _____

   Will the family member need to have treatment visits at least twice per year due to the condition? ☐ Yes ☐ No

   Was the family member referred to other Health Care Provider(s) for evaluation or treatment (e.g., physical therapist)? ☐ Yes ☐ No

   If so, state the nature of such treatments and expected duration of treatment: _____

   _____

2. Is the medical condition pregnancy? ☐ Yes ☐ No If so, expected/actual delivery date: _____
3. Complications with the pregnancy or delivery? ☐ Yes ☐ No Please explain: _____

   _____

   _____

   _____

4. Describe other relevant medical facts, if any, related to the condition for which the family member needs care (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment):

   _____

   _____

   _____

5. Is the family member an active service member? ☐ Yes ☐ No

   If yes, is the condition a result of military service? ☐ Yes ☐ No

PART B: AMOUNT OF CARE NEEDED: When answering these questions, keep in mind that your family member's need for care by the employee seeking leave may include assistance with basic medical, hygienic, nutritional, safety or transportation needs, or the provision of physical or psychological care:

6. Will the family member be incapacitated for a single continuous period of time, including any time for treatment and recovery? ☐ Yes ☐ No

   Estimate the beginning and ending dates for the period of incapacity: _____

   During this time, will the family member need care? ☐ Yes ☐ No

   Explain the care needed by the family member and why such care is medically necessary: _____

   _____

   _____

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Paid Family And Medical Leave Certification For Care Of Family Member (Form PFML-4)

7. Will the family member require follow-up treatments, including any time for recovery? ☐ Yes ☐ No

   Estimate treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including any recovery period: _____

   _____

   _____

   Explain the care needed by the family member, and why such care is medically necessary: _____

   _____

   _____

8. Will the family member require care on an intermittent or reduced schedule basis, including any time for recovery? ☐ Yes ☐ No

   Estimate the hours the family member needs care on an intermittent basis, if any:

   _____ hour(s) per day; _____ days per week from _____ through _____

   Explain the care needed by the family member, and why such care is medically necessary: _____

   _____

   _____

9. Will the condition cause episodic flare-ups periodically preventing the family member from participating in normal daily activities?

   ☐ Yes ☐ No

   Based upon the family member's medical history and your knowledge of the medical condition, estimate the frequency of flare-ups and the duration of related incapacity that the family member may have over the next 6 months (e.g., 1 episode every 3 months lasting 1-2 days):

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

   Duration: _____ hours or ____ day(s) per episode

   Does the family member need care during these flare-ups? ☐ Yes ☐ No

   Explain the care needed by the family member, and why such care is medically necessary _____

   _____

   _____

ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER.

Health Care Provider's Name			Date	
Address	City		State	ZIP
Phone No.	Fax No.			
Specialty/Type of Practice		License No.	State	State Identification Number

Declaration and signature

My signature attests that the information provided in this form is true and correct, that I have examined the patient and answered the questions accurately and to the best of my ability, and that I am a health care provider authorized to certify their condition.

Signature of Health Care Provider	Date

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

We want to offer you the option to address any tax obligation by providing the ability to voluntarily request tax obligations withdrawn from your Minnesota PFML benefit. You can have both Federal and Minnesota State tax withheld from your Paid Family and Medical Leave Benefits. Taxes will be withheld after deductions are taken.

- Withholding Federal and/or Minnesota State Tax is voluntary. 10% of your benefits would be withheld for Federal taxes and 6.25% would be withheld for Minnesota State taxes.
  - If you do not have Federal and/or Minnesota State income tax withheld, you may need to make estimated quarterly tax payments.
- The Federal and Minnesota State Tax withheld during the year will be reported on a Tax Form that is mailed after the end of the year.

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

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

To **start or stop** withholding 10% Federal and/or 6.25% Minnesota 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 6.25% MN State Income Tax.
- ☐ **Stop** withholding 6.25% MN State Income Tax.

Signature: _____ **Date:** _____

Declaration and signature: Some states require us to inform you that any person who knowingly and with intent to injure, defraud or deceive an insurance company, or other person, files a statement containing false or misleading information concerning any fact material hereto commits a fraudulent insurance act which is subject to civil and/or criminal penalties, depending upon the state. Such actions may be deemed a felony and substantial fines may be imposed.

Print