Reset

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 For:
Your own 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-6
- ☐ Complete PFML-6 and give to Health Care Provider
- ☐ Health Care Provider keeps PFML-6

Complete Form PFML-7
- ☐ Complete “Employee” information at the top of PFML-7
- ☐ Provide PFML-7 to your Health Care Provider
- ☐ Health Care Provider completes PFML-7 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 Colorado Paid Family And Medical Leave (Form CO PFML-1) Instructions

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

Colorado Paid Family And Medical Leave (CO 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 or psychological assistance as used for leave taken to care for a Family Member with a Serious Health Condition.
Safe leave means any period of leave because the Covered Individual or the Covered Individual's Family Member is the victim of Domestic Violence, the victim of Stalking, or the victim of sexual assault or abuse.
Military exigency means a period of leave needed to accommodate a Family member on active duty military service or being called to active duty military service.
Own Serious Health Condition due to pregnancy means any period of disability due to pregnancy or childbirth or related complications.
Own Serious Health Condition (other) means an illness, injury, impairment, or physical or mental condition of an Eligible Employee.

Question 10: Family Member means a Child, Parent, Spouse, Grandparent, Grandchild or Sibling; or any other individual with whom the Covered Individual has a significant personal bond that is or is like a family relationship.

Child means biological children (regardless of age), step-children, legal wards, or a child to whom the employee stands in loco parentis to the employee or the employee's spouse or domestic partner when they were minors.

Grandchild means a child of the employee's child.

Grandparent means a parent of the employee's parent.

Parent means the biological, step-parent, or an individual who stood in loco parentis to the employee or the employee's spouse or domestic partner when they were minors.

Sibling means the Covered Individual's, or the Covered Individual's Spouse's sibling or step-siblings.

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

Significant Personal Bond means any other individual with whom the covered individual has a family relationship, regardless of biological or legal relationship.

The following factors will be considered:

Shared financial responsibility, including shared leases, common ownership of real or personal property, joint liability for bills, or beneficiary designations;
Emergency contact designations;
The expectation of care created by the relationship;
Cohabitation and the duration thereof; and
Geographical proximity.

Question 11: If dates are "Continuous", the employee must provide the start and end dates of the requested CO PFML. These dates should be the actual dates that the CO 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 CO 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 CO 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 CO PFML request to their employer with less than 30 days' advance notice from the start date of the CO 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 CO PFML. Include the type/name of income and how much. Example PTO from employer for $500.00 a week.

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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 CO 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" include, but are not limited to, salary, wages, tips, commissions, and other compensation.

"Average Weekly Wage" means the Covered Individual's weekly Wages in effect with the Employer on the Day immediately preceding the date PFML begins.

For Covered Individuals who are paid hourly, the Average Weekly Wage is based on the hourly pay rate multiplied by the number of hours regularly scheduled to work for the Employer per week. If the Covered Individual does not have regular work hours, the Average Weekly Wage is based on the average number of hours worked per week for the Employer during the preceding 52 calendar weeks (or during the period of Employment with the Employer if less than 52 weeks). If a Covered Individual is paid on an annual contract basis, the Average Weekly Wage is based on one-fifty-second (1/52nd) of the Covered Individual's annual contract salary with the Employer.

Question 9: Regular Work Schedule means the Days of the week and the number of hours typically worked by the Covered Individual in the job or jobs held by the Covered Individual as of the first date of the PFML. Regular work schedule shall be determined by taking an average of the schedule worked during the 4 weeks prior to the last Day worked. If the Covered Individual has worked fewer than 4 weeks, the average shall only include the weeks in which the Covered Individual was employed by the Employer. For purposes of calculating a regular work schedule, Days missed due to paid sick leave, paid time off, holiday pay, or other Employer-provided leave must be included.

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

Internally sponsored paid family and medical leave is a separate bank of time off solely for the purpose of paid family and medical leave provided by an employer which may only be used for CO PFML qualifying reasons.

Employer-Provided Paid Leave means vacation leave, paid sick leave, paid personal leave, and any other employer-paid time off. Employer-provided paid leave does not include benefits under a short-term disability policy, long term disability policy, or a separate bank of time off solely for the purpose of paid family and medical leave.

Question 12: To qualify for reimbursement the Employer must pay Wage continuation or from a separate bank of time off solely for the purpose of paid family and medical leave to the covered Individual that is equal to or greater than the Weekly Benefit Amount. The Employer is not eligible for reimbursement for Employer-Provided Paid Leave paid to the Eligible Employee.

Question 13: If leave is caused by circumstances that entitle an individual to Workers' Compensation Benefits, the employee is not entitled to PFML.

If leave is caused by circumstances that entitle an individual to Unemployment Insurance Benefits, the employee is not entitled to intermittent or reduced schedule PFML.

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

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

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

9. Reason for CO PFML request:
Bonding: ☐ New child ☐ Adoption/Foster child
☐ Care of Family Member with a Serious Health Condition / Neonatal Intensive Care ☐ Safe Leave ☐ 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
☐ Significant Personal Bond (affirm & provide detail in a. and b. below)

a. I hereby assert that a family-like relationship exists between _____
Your Name

_____
Name of person you have a family-like bond with

b. Describe how this relationship demonstrates a family relationship: _____

c. If Neonatal Intensive Care: Infants(s) name: _____ Infant(s) date of birth: _____

Gestational age at delivery (**required**): _____ NICU admission date (**required**): _____

NICU discharge date, if known: _____

11. Will CO 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 or Unemployment Insurance Benefits? ☐ Yes ☐ No If yes, are you receiving permanent partial disability (PPD) benefits from a workers' compensation claim? (PPD benefits are not the same as Temporary Workers' Compensation benefits.) ☐ Yes ☐ No

19. List income you will be receiving while on CO PFML, source of pay and amount.

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Request For
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(Form CO 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)

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 CO PFML benefits received by the employee, such as payments received and types of leave, will be provided to the employer.

Declaration and signature
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 a 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.

Employee's signature	Date signed (MM/DD/YYYY)

☐ I am submitting this form in advance (see instructions about pre-submitting). I understand the insurance carrier will contact me to advise how to submit the required missing information.

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 CO 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 to work due to lapses in seasonal operations, school breaks, or other suspensions or cessations of business operations while on PFML leave, excluding holidays:
(example: December 18 - January 1 and March 25 - March 31 or N/A if not applicable)
_____

11. Will wage continuation or internally sponsored paid family and medical leave be paid during the CO PFML leave period/dates? ☐ Yes ☐ No
If yes, provide dates: _____

12. If employee received or will receive wage continuation or internally sponsored paid family and medical leave while on CO 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. CO PFML policy number

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

CO PFML insurance carrier's name and mailing address
Standard Insurance Company PO Box 3877, Portland, OR 97208 866-751-5174 Fax

Declaration and signature

☐ 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 a 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.

Employer's authorized signature	Date signed (MM/DD/YYYY)

Title

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Paid Family and Medical Leave
Release of Information for Own Serious Health Condition
(Form PFML-6)

Notice to the Employee About Use of this Authorization

As you may know, the Paid Family And Medical Leave Act (PFML) permits an employer or leave administrator to contact an employee's Health Care Provider, with the employee's permission, for the purpose of clarifying or authenticating an otherwise complete and sufficient PFML medical certification. For PFML purposes, "clarifying" means to understand the meaning of a response or to understand the handwriting and "authenticating" means to provide the Health Care Provider with a copy of the medical certification to verify the information on the form.

To help streamline PFML administration and minimize the need to contact you during leave, we have developed the attached PFML Authorization. By signing the Authorization, you provide Standard Insurance Company (The Standard) permission to contact your Health Care Provider to clarify and/or authenticate medical certifications under PFML. You are not required to complete and sign the Authorization for The Standard to process your request for PFML leave. However, completing and signing the Authorization now may shorten the time it takes to clarify or authenticate a medical certification later.

If you decide to sign the Authorization now, you may still revoke it at any time. In addition, before contacting your Health Care Provider to clarify and/or authenticate a medical certification, we will notify you in writing and explain the: (1) specific reason(s) we want to clarify and/or authenticate the certification; (2) information required to clarify and/or authenticate the certification; and (3) time period within which you and/or your Health Care Provider must provide the information needed to clarify and/or authenticate the certification.

If you would like us to authorize now any future PFML clarification or authentication, please review the Authorization carefully and complete, sign and return the Authorization to the address above.

I authorize any physician, medical practitioner or Health Care Provider (referred to as "health provider") who has completed a medical certification form for _____ (patient name) to discuss with or disclose to STANDARD INSURANCE COMPANY, my health information needed to clarify statements or information provided by health provider on a medical certification form which had been completed by health provider.

- I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct my health provider to release and disclose without restriction information reasonably necessary to clarify or authenticate information provided on a previously completed medical certification form.
- I have the right to refuse to sign this authorization and a right to revoke this authorization at any time by sending a written statement to The Standard, 1100 SW Sixth Avenue, Portland OR 97204, except to the extent the authorization has been relied upon to clarify or authenticate information. A revocation of the authorization, or the failure to sign the authorization, may impair The Standard's ability to evaluate or process the request for leave of absence.
- I understand that in the course of conducting its business The Standard may disclose information to my employer regarding my leave of absence request and status, including a completed return to work authorization form.
- I understand that the information disclosed to The Standard pursuant to this authorization may be subject to redisclosure with my authorization or as otherwise permitted or required by federal or state law. Information retained and disclosed by The Standard may not be protected under the Health Insurance Portability and Accountability Act [HIPAA].
- I understand and agree that this authorization is valid for 12 months from the date signed below.
- A photocopy or facsimile of this authorization is as valid as the original and will be provided to me upon request.

Name (please print)	
Signature of Claimant/Representative	Date

If signature is provided by legal representative (e.g., Attorney in Fact, guardian or conservator), please attach documentation of legal status.

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Paid Family And Medical Leave Certification for Own Serious Health Condition (Form PFML-7)

Employee's Name	Date of Birth

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: _____

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

   Was the patient 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 patient for condition: _____

   _____

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

   Was the patient 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 pregnancy or delivery? ☐ Yes ☐ No If yes please explain: _____

   _____

   _____

   _____

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

   _____

   _____

   _____

PART B: AMOUNT OF LEAVE NEEDED

5. Will the employee be incapacitated for a single continuous period of time due to his/her medical condition, including any time for treatment and recovery? ☐ Yes ☐ No

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

6. Will the employee need to attend follow-up treatment appointments or work part-time or on a reduced schedule because of the employee's medical condition? ☐ Yes ☐ No

   If so, are the treatments or the reduced number of hours of work medically necessary? ☐ 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: _____

   _____

   _____

   _____

   Estimate the part-time or reduced work schedule the employee needs, if any:

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

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Paid Family And Medical Leave Certification for Own Serious Health Condition (Form PFML-7)

Employee's Name	Date of Birth

7. Will the condition cause episodic flare-ups periodically preventing the employee from performing his/her job functions? ☐ Yes ☐ No

   Is it medically necessary for the employee to be absent from work during the flare-ups? ☐ Yes ☐ No

   If so, explain: _____

   _____

   _____

   _____

   Based upon the patient's medical history and your knowledge of the medical condition, estimate the frequency of flare-ups and the duration of related incapacity that the patient 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

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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Paid Family and Medical Leave (PFML) Voluntary Federal Income 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 PFML benefit. You can have Federal tax withheld from your Paid Family and Medical Leave Benefits. Taxes will be withheld after deductions are taken.

- Withholding Federal Tax is voluntary. 10% of your benefits would be withheld for Federal taxes.
  - If you do not have Federal income tax withheld, you may need to make estimated quarterly tax payments.
- The Federal 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 government as part of your income tax refund.

To **start or stop** withholding 10% Federal 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.

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.

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