Standard Insurance Company

866.756.8116 Tel 866.751.5174 Fax
PO Box 3877 Portland OR 97208

# 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.**

Reset

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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 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) |
|---|---|
| | |

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

## 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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**Colorado Paid Family and Medical Leave**
**Safe Leave Attestation**
**(Form CO PFML-8)**

## Important Directions for Completing Your Request for Benefits:

To request benefits, you must complete this form and return it to us with your Application and other supporting document(s) as described below. Incomplete or missing information may result in a delay in claim processing.

"Safe Leave" means any leave because the employee or the employee's family member is the victim of domestic violence, the victim of stalking, or the victim of sexual assault or abuse.

"Domestic violence" means any conduct that constitutes "domestic violence" as set forth in C.R.S. § 18-6-800.3 (1) or § 14-10-124 (1.3) (a) or "domestic abuse" as set forth in § 13-14-101 (2).

"Stalking" means any act as described in C.R.S. § 18-3-602.

"Sexual assault or abuse" means any offense as described in C.R.S. § 16-11.7-102 (3), or sexual assault, as described in § 18-3-402, committed by any person against another person regardless of the relationship between the actor and the victim.

**ATTESTATION:** I attest that I am in need of Safe Leave as follows (check those that apply):

☐ I am a victim of domestic violence, stalking, or sexual assault or abuse as defined above.
☐ My family member identified below is a victim of domestic violence, stalking, or sexual assault or abuse as defined above.

| Name (please print) | Relationship to me |
|---|---|
| Signature of Claimant | 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 (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.**

Print