Fax or mail completed application to:
Group Claims Department
P.O.Box 14294
Lexington, KY 40512-4294
Fax Number: (855) 864-0530
claimsubmission@groupclaims.com

NOTICE OF MASSACHUSETTS PAID FAMILY AND MEDICAL LEAVE CLAIM

EQUITABLE

Equitable Financial Life Insurance Company
Equitable Financial Life Insurance Company of America *
For Assistance
Call (866) 274 9887

PART A CLAIMANT INFORMATION TO BE COMPLETED BY THE CLAIMANT - PRINT OR TYPE

1. Name: (Last, First, Middle) as shown on your Social Security card.	2. Social Security Number:	3. Birth Date:

4. Gender:	5. Home/Cell Number:	6. Marital Status:
☐ Male ☐ Female ☐ Not Designated /Other	( )	☐ Single ☐ Married

7. Preferred E-Mail Address while on leave:

8. Mailing address : (Street, City or Town, State, Zip Code)

9. Employer Name:	10. Employer Telephone Number: ( )
11. Employer Address: (Street, City, State & Zip Code)	12. Occupation:

13. Reason for Leave:

☐ Own Serious Health Condition
☐ Bond with a Child
☐ Leave related/due to Family Member's Military Active Duty or order to Active Duty
☐ Care of Family Member with Serious Health Condition
☐ Care of Family Member who is Servicemember with Illness/Injury Related to Military Service

14. If leave is to care for a family member, the family member is the employee's:

☐ Child
☐ Spouse
☐ Domestic Partner
☐ Parent
☐ Parent In-Law
☐ Grandparent
☐ Grandchild
☐ Sibling

Family Member Name: _____

15. Will leave be for a continuous period of time and/or intermittent (periodic) or a reduced work schedule?

☐ Continuous Start Date: _____ End Date: _____

☐ Intermittent Identify dates intermittent leave will likely be taken, if known: _____

☐ Reduced Schedule Start Date: _____ End Date: _____

16. Date notice provided to Employer: _____ If providing less than 30 days' advance notice to the employer, please explain:

PART A (Continued)

Other Employment information - If you worked for other employers in Massachusetts during the past 15 months, besides the Employer identified in question 9 above, complete the below information. Include full-time and part-time employment. If you had more than 2 employers, list on a separate sheet and attach to this form. Please include wages received for the last four completed calendar quarters immediately prior to the start date of the leave request. A calendar quarter is January – March, April – June, July – September and October – December. Hours worked should reflect total hours worked within each calendar quarter.

17. Other Employer Name:	18. Telephone Number: ( )	19. Period of Employment: From: To:
20. Address: (Street, City, State & Zip Code)	21. Work Location:	

	CALENDAR QUARTER	TOTAL GROSS EARNINGS	TOTAL HOURS WORKED
1			
2			
3			
4			

22. Other Employer Name:	23. Telephone Number: ( )	24. Period of Employment: From: To:
25. Address (Street, City, State & Zip Code)	26. Work Location	

	CALENDAR QUARTER	TOTAL GROSS EARNINGS	TOTAL HOURS WORKED
1			
2			
3			
4			

27. I request voluntary Federal Tax Withholding ☐ Yes ☐ No If "Yes," indicate the amount to be withheld from weekly benefits.

($20.00 minimum withholding per week) _____

28. CERTIFICATION AND SIGNATURE

I was unable to work during the period for which I am claiming benefits, and I hereby certify that I have read and understand my benefits rights. I also certify that the information I completed on this form are true and accurate. I am aware that if any of the information I completed on this form are knowingly false, I may be subject to penalties which may include criminal prosecution. I am hereby authorizing you to obtain any medical, employment and wage information you need to determine my eligibility for this benefit, and to share any such information with my employer as may be necessary to process benefits and in accordance with applicable law.

If your employer has agreed to continue your regular pay while you are unable to work, do you agree to have the benefits available to you under this policy routed through your employer? ☐ Yes ☐ No Please sign: _____

Note: A "No" answer could impact you continuing to receive your regular pay from your employer in exchange for the benefits available to you from this policy.

Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties. Any person who includes any false or misleading information on an application for insurance policy is subject to criminal and civil penalties.

Electronic Funds Transfer (EFT) is our standard method of benefit payment. When making our claim decision we may contact you to obtain your banking information.

SIGN HERE _____ _____

(Claimant's Signature) (Date)

Equitable Financial Life Insurance Company
Equitable Financial Life Insurance Company of America *
For Assistance
Call (866) 274 9887

Certification of Serious Health Condition

Massachusetts Paid Family and Medical Leave (MA PFML)

Section I - For Completion by Employee: Complete the Employee Information section and give it to your health care provider to complete. Have your provider return the completed form to you. You will need to return this form to Equitable Financial Life Insurance Company of America, as soon as possible so that we can evaluate your claim.

Forms can be mailed to: Group Claims Department
P.O. Box 14294
Lexington, KY 40512-4294
Toll Free Fax (855) 864-0530

Faxed or emailed to: claimsubmission@groupclaims.com

Employee Information

Employee's Name: Last 4 digits of Social Security Number:

Leave ID: Date of Birth:

Employer's Name:

Today's Date:

Employee's Job Title: Regular Work Schedule:

If you are applying to care for a family member complete the information below.

The family member who is experiencing a serious health condition is my:

☐ Child ☐ Grandparent ☐ Parent

☐ Sibling ☐ Spouse or Domestic Partner

☐ Grandchild ☐ Spouse's or Partner's Parent

Patient's Full Name: _____ Date of Birth: _____

Section II - For Completion by the Health Care Provider: (See Part A and Part B attached)
INSTRUCTIONS to the HEALTH CARE PROVIDER: Please read the definition of a serious health condition below and refer to it while filling out the form. This form should be filled out by the healthcare provider of the patient, who may or many not be the employee. For the employee to qualify for paid leave, the patient must have a serious health condition. Answer all questions fully and completely.

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic information" as defined by GINA, includes the manifestation of disease or disorder in family members of the individual, an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services and genetic information of a fetus carried by an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Provider's name:

Provider's Business Address:

Type of Practice/Medical Specialty:

Telephone Number: ( )

Fax Number: ( )

Definition of a serious health condition

A serious health condition could include an illness, injury, impairment or physical or mental condition that involves at least one of the following two conditions:

1. At least one night of inpatient care in a hospital, hospice or residential medical facility
2. Continuing treatment by a health care provider

Inpatient care
An overnight stay in a hospital, hospice, or residential medical care facility, including any period of incapacity, or any subsequent treatment in connection with such inpatient care.

Continuing treatment by a health care provider for a condition that fits any of the following descriptions:

A. Any incapacity to work for more than three consecutive full calendar days that also requires medical visits. The patient's first visit must be within seven days of the start of incapacity. Telehealth appointments are also included. These medical visits must meet one of the following two patterns:
   - Two or more visits within 30 day of a patient's incapacity to work (unless it is impossible to book two appointments in this timeframe).
   - One such visit-excluding a routine physical, eye or dental exam – plus a regiment of care or medication under the provider's supervision or prescription. E.g. outpatient surgery or strep throat

B. Any incapacity due to pregnancy or prenatal care

C. Any incapacity due to a chronic condition, which is a condition that:
   - Requires periodic medical visits,
   - Continues over an extended period of time, and
   - May cause episodic periods of incapacity that require leave. E.g., asthma or migraine headaches

D. Any incapacity due to a permanent or long-term condition that may not respond to treatment. E.g. Alzheimer's disease or terminal states of cancer

E. Any absence to receive multiple treatments, plus any recover time, for either of the following:
   - Restorative surgery after an accident or injury. E.g. joint replacements or reconstruction
   - A condition that would lead to more than three consecutive days of incapacity if the patient did not receive treatment. E.g. chemotherapy treatments.

Incapacity
An inability to perform the functions of one's job due to the serious health condition. For unemployed applicants, it means an inability to perform the function of their most recent position or other suitable employment.

PART A - Patient's Serious Health Condition (For Completion by the Health Care Provider)

1) Does the patient have a serious health condition? ☐ Yes ☐ No

2) Which of the following apply to the patient's serious health condition? (Check all that apply)

The Condition:

- ☐ Requires or did require inpatient care
- ☐ Has incapacitated or will incapacitate the patient for more than three consecutive full calendar days
- ☐ Requires two or more medical visits within 30 days
- ☐ Requires one medical visit, plus regimen of care
- ☐ Is chronic, requires treatments at least twice a year, and may require period absences
- ☐ Is long-term and requires ongoing medical supervision, with or without Active treatment
- ☐ Requires multiple treatments and would lead to a period of incapacity without treatment

3) Provide appropriate medical facts to allow an understanding of how the condition may affect the patient's ability to work. Examples may include symptoms, hospitalizations, medical visits, relevant side effects to medication, and referrals for evaluation or treatment.

4) When did the condition begin? This is the start of the condition, not the start of the employee's leave from their job. If it cannot be determined, provide a start date to the best of your ability.

☐ This condition began within the past 12 months. ☐ This condition began more than one year ago.

Start Date: _____

5) Is the patient's serious health condition a pregnancy-related issue that results in some level of incapacity prior to giving birth?

☐ Yes Expected delivery date: _____ ☐ No

6) Is this health condition a job-related injury? ☐ Yes ☐ No

7) If the patient is not the employee, is this health condition related to the patient's military service?

☐ Yes ☐ No ☐ N/A, the patient is the employee

8) If the patient is not the employee, will the patient require care from a family member?

☐ Yes ☐ No ☐ N/A, the patient is the employee

PART B - Ability to Work: (For Completion by the Health Care Provider)

Provide your best estimate based on your medical knowledge, experience, and examination of the patient. Be as specific as you can be; terms like "unknown" or "indeterminate" may not be enough to approve a claim for paid leave benefits. This section establishes the start and end dates when the employee needs leave due to their own incapacity of the incapacity of a family member because of the serious health condition. This date range is the leave period. A leave period cannot be approved for longer than six months. If the condition requires additional leave after six months or a re-evaluation, the employee can submit a new application at that time with a new certification.

1) When will the employee first need to take leave? This is the first day of missed time from work, regardless of whether it is a partial or a full day. If any time has already been missed because of this condition, enter the earliest absence.

   Start Date: _____

2) Do you know the last day the employee will need leave for the patient's condition? If you cannot determine this, when do you recommend re-evaluating? (Check only one)

   ☐ Yes The last day the employee will need leave is: _____

   ☐ No The patient's condition should be re-evaluated on: _____

3) During this leave period, which of these patterns of leave do you expect the employee to need as a result of the patient's condition?

   ☐ Continuous leave (e.g., Completely unable to work for consecutive, uninterrupted days)

   ☐ Reduced leave schedule (e.g., A consistent but reduced schedule for multiple weeks)

   ☐ Intermittent leave (e.g., Episodic time off at irregular intervals for flare-ups or unexpected aftercare)

4) If the patient is the employee is it your medical opinion that the patient must refrain from working, either partly or completely, between the dates you provided, as a result of their serious health condition?

   ☐ Yes ☐ No

5) Describe specific activities the patient should refrain from, either partly or completely, as a result of their serious health condition. If a patient must be absent from their job for treatment, state this directly. If the patient needs to be absent for any reason other than receiving treatment, describe specific tasks, actions, or function they cannot perform due to their condition.

6) If the patient is a family member is it your medical opinion the patient needs care from the employee seeking leave, as a result of their serious health condition?

   ☐ Yes ☐ No

PART B - Ability to Work: (For Completion by the Health Care Provider) - Continued

7) ☐ **Continuous leave needed:** When will the continuous leave period start and end?

Start Date: _____ End Date: _____

☐ **Reduced leave schedule needed:** When will the reduce leave schedule start and end?

Start Date: _____ End Date: _____

How many hours should the employee take off per week?

_____ Hour(s) per day _____ Days per week

☐ **Intermittent leave needed:** When will the intermittent leave schedule start and end?

Start Date: _____ End Date: _____

Estimate the frequency and duration of intermittent leave needed, if any, over the next 6 months including any recovery period:

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

Duration: _____ hour(s) or _____ day(s) per episode/treatment

Dates of scheduled treatment(s)/appointment(s):

_____

I certify 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**

_____ _____

Signature of Employee **Date**

PFML Coverage Certification Report

EQUITABLE

DATE: __/__/____

Once complete please return to equitable@groupclaims.com or via fax: (855)864-0530.

Policy/Plan Holder Name: _____

Claimant Name:_____ Job title: _____ Date of Hire: _____
SSN: ###-##-####_____
Address: _____ STD effective date _____ Prior coverage dates _____
_____
Phone No.: (___) ___ - ____ LTD effective date _____ Prior coverage dates _____
Email Address: _____

Employment Status: Active_____ Terminated_____ If Terminated provide date of termination: __/__/____

Does this employee meet the definition of a MA Employee/Worker? ___Yes ___No

PFML leave start date: __/__/____ Last Date Worked: __/__/____

Did employee work a full day? __ Yes __ No If not, how many hours did they work? _____

What are the employee's physical job demands (pushing, pulling, standing, sitting, etc.): _____

Are you able to offer job accommodations to facilitate a return to work?_____

Is their condition work related? ___Yes ___No If yes, have they applied for WC benefits? ___Yes ___No

Is the Employee taking FMLA concurrently with PFL? ___Yes ___No

Leave Type: __ Continuous __ Intermittent

If applicable, please advise if your employee has been approved for MA Paid Family or Medical Leave benefits at all in the 12 Months preceding the start date of this leave? ___Yes ___No

If yes, please indicate the type of leave taken and provide the inclusive dates as well as the total time approved:

Leave Type	From	Through	Hours Approved
PFL Bonding			
PFL Care of Family			
PFL Care of Service Member			
PFL Military Exigency			
PML – Employee Own Illness			

Scheduled work days: _____ Number of hours worked per week: _____

Taxable Percent of MA PML Benefit: _____

EQUITABLE

Earnings and Hours Worked. Please complete the grid below using the following guidance:

Total Gross Earnings Received and Total Number of Hours Worked, subject to MA PFML Law, by quarter during the base period.

Base Period means: the last four completed calendar quarters immediately preceding the start date of the Paid Family and Medical Leave

If employee has been working for less than the qualifying base period, provide the number of weeks they worked and/or were paid for.

	CALENDAR QUARTER	TOTAL GROSS EARNINGS	Total Hours Worked
1			
2			
3			
4			

Will the employer be making payments to the employee from a qualifying employer sponsored policy or program that are equal to or greater than the MA PFML benefit while on leave? Yes ___ No ___

Will the employer be requesting reimbursement? Yes ___ No ___
If yes, please provide the dates From__/__/____ Through__/__/____

Has the employee chosen to receive an accrued paid leave benefit such as PTO or accrued sick leave in lieu of MA Paid Family or Medical Leave benefit*(i.e., not a supplemental payment/top up)? Yes ___ No ___
If yes provide dates From__/__/____ Through __/__/____

**Note: Accrued Paid Leave time is not reimbursable. Employers are required to notify employees that Accrued Paid Leave time runs concurrently with MA Paid Family or Medical Leave and will be decremented from the employee's total Available allotment.*

Please complete the following for STD and LTD benefits

Is this employee a Union member? Yes ___ No ___

Is the employee Hourly ____ or Salary ____ ?

Taxable Percent of STD Benefit: _____ Taxable Percent of LTD Benefit: _____

What is this employee's weekly or hourly rate of pay? $_____

Is this employee receiving salary continuation or sick leave? _____ If yes, please provide dates and payment amount.
From__/__/____ Through__/__/____ $_____

Completed by: _____ Date: _____

Phone Number: _____ Email: _____

Electronic Funds Transfer (EFT) Request Form

Clear Form

Instructions

1. Read the Terms and Conditions listed below.

2. Enter your name, address, home telephone number and Employee ID.

3. Complete the bank and account information for your Electronic Funds Transfer request.

4. You and all other parties to the account specified must sign this form.

5. Return the completed form to Claims Office.

Note: Failure to provide the requested information may affect the processing of this form and may delay or prevent the receipt of payments through the EFT Program.

Name: _____

Address: _____

Telephone Number: ( ) - _____

Employee ID: _____

Name of Bank: _____

Bank Address: _____

Bank Telephone Number: ( ) - _____

Type of Account (select one):

Checking: **Saving:**

Account Number: _____ Account Number: _____

Bank Routing Number: _____

Attach a voided blank personal check.

Indicate any other names on the account selected:

_____

AUTHORIZATION

I / We authorize Equitable _____ hereinafter called "The Insurance Company" and/or its Third Party Administrator, hereinafter called "TPA", to initiate credit entries (and to initiate, if necessary, debit entries and adjustments for credit entries made in error) to my (our) account indicated above and the Depository named above, hereinafter called Depository, to credit and/or debit the same to such account. I (we) acknowledge that the origination of ACH transactions to my (our) account must comply with the provisions of U.S. law. This authorization is to remain in full force and effect until The Insurance Company and/or its TPA has received written notice from me (us) of its termination in such time and in such manner as to afford The Insurance Company and/or its TPA and Depository a reasonable opportunity to act on it.

_____ _____

Signature(s): **Date:**

_____ _____

TERMS AND CONDITIONS

The Insurance Company and/or its TPA will not be responsible for any banking fees charged for direct deposit or electronic funds transfer.

I understand that this agreement may be terminated by me upon written notice to The Insurance Company and/or its TPA.

The cancellation will be processed for the time period following receipt of the notice.

I understand that a change in the title of this account which alters the interest of any party terminates this authorization and that a new authorization must then be submitted to continue direct deposit/EFT.

I understand that it is my responsibility to inform The Insurance Company and/or its TPA of any address changes immediately.

I further understand that any benefit payment forwarded to the financial institution covering a period of time after my death will be refunded to The Insurance Company and/or its TPA. I agree that the financial institution shall hathe right of offset for such a refund.

I authorize the financial institution specified in this authorization to provide The Insurance Company and/or its TPA with my home address and the names of any joint account holders for the account specified here in.

I understand that I am responsible for verifying the accuracy of my account data and for promptly notifying The Insurance Company and/or its TPA of any errors or changes including termination of my EFT request.

SPECIAL NOTICE TO OTHER PARTIES TO THIS ACCOUNT.

As a party to this account, I understand that I am personally liable, both individually and as a member of the group of parties to this account, for the full amount of all benefit payments covering any period after the death of the disability benefit recipient. This is a liability to The Insurance Company and/or its TPA. If I am entitled to any benefit as the beneficiary of the disability benefit recipient, the amount of my liability may be deducted from the amount payable to me. I agree that the financial institution shall have the right of offset for such a refund, and I authorize the financial institution to provide The Insurance Company an/or its TPA with my home address.

CANCELLATION

The agreement represented by this authorization remains in effect until cancelled by the recipient by notice to The Insurance Company and/or its TPA or by the death or legal incapacity of the recipient. Upon cancellation by the recipient, the recipient should notify the receiving financial institution that he/she is doing so. The agreement represented by this authorization may be cancelled by the financial institution by providing the recipient a written notice 30 days in advance of the cancellation date. The recipient must immediately notify The Insurance Company and/or its TPA if the authorization is cancelled by the financial institution. The financial institution can not cancel the authorization by advice to The Insurance Company and/or its TPA.

_____ _____

Signature: Date:

I certify that I have read and understand the Terms and Conditions of this EFT Agreement, including the SPECIAL NOTICE TO OTHER PARTIES TO THIS ACCOUNT.

_____ _____

Signature(s) of Other Persons on Account: Date

_____ _____

Date: