Fax or mail completed application to:
Group Claims Department
P.O. Box 14294
Lexington, KY 40512-4294
Fax 1-855-864-0530
Phone Number: (866) 274-9887
claimsubmission@groupclaims.com

NOTICE OF CONNECTICUT PAID FAMILY AND MEDICAL LEAVE CLAIM

EQUITABLE

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: ☐ Male ☐ Female ☐ Not Designated /Other
5. Home/Cell Number: ( )
6. Marital Status: ☐ 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 ☐ Bonding ☐ Adoption ☐ Fostercare ☐ Care of Family Member

☐ Care of a Service member ☐ Active Duty Exigency ☐ Victim of Family Violence ☐ Organ/Bone Marrow Donation

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

☐ Child ☐ Grandparent ☐ Spouse's Grandparent
☐ Spouse ☐ Grandchild ☐ Spouse's parent
☐ Sibling ☐ Spouse's Child ☐ Parent
☐ Sibling in Law ☐ Next of Kin ☐ Blood Relative or Existing Affinity Relationship

Family Member Name: _____

15. Is this request for a work-related inllness or injury? ☐ Yes ☐ No
16. Are you receiving unemployment benefits? ☐ Yes ☐ No
17. 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: _____

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

19. If the family member is an individual related to you by blood or affinity (including a person who stood in loco parentis to you stand in loco parentis) you must complete this section.

I am asserting that an affinity relationship exist between _____ and _____ . (Applicant Name)

20. Please describe how this relationship demonstrates a family relationship.

PART A (Continued)

Other Employment information - If you worked for other employers in Connecticut 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.

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

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

26. Other Employer Name:	27. Telephone Number: ( )	28. Period of Employment: From: To:
29. Address (Street, City, State & Zip Code)	30. Work Location	

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

31. CERTIFICATION AND SIGNATURE

I am 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 is 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.
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)

Certification of Serious Health Condition

Connecticut Paid Family and Medical Leave (CT PFML)

EQUITABLE

Equitable Financial Life Insurance Company of America *

For Assistance
Call (866) 274-9887

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

Fax or Email to: Toll Free Fax 1-855-864-0530
Phone Number: (866) 274-9887
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:

Please identify the reason for leave:

☐ Own Serious Health Condition ☐ Pregnancy ☐ Bonding ☐ Adoption ☐ Fostercare

☐ Care of Family Member ☐ Care of a Service Member ☐ Active Duty Exigency

☐ Victim of Family Violence ☐ Organ/Bone Marrow Donation

If you are applying for your own condition, is your condition work related? ☐ Yes ☐ No

If you are applying to care for a family member, identify the family member who is experiencing a serious health condition:

☐ Child ☐ Grandparent ☐ Spouse's Grandparent ☐ Spouse ☐ Grandchild

☐ Spouse's Parent ☐ Sibling ☐ Spouse's Child ☐ Parent ☐ Sibling in Law

☐ Next of Kin ☐ Blood relative or exiting affinity relationship

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

If the family member is an individual related to you by blood or affinity (including a person who stood in loco parentis to you or for whom you stand in loco parentis) you must complete this section.

I am asserting that an affinity relationship exist between _____ and _____.
(Applicant Name)

Please describe how this relationship demonstrations a family relationship.

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 means an illness, injury, impairment or physical or mental condition that involves:

1. Inpatient care or
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. A period of incapacity of more than three consecutive calendar days, and any subsequent treatment or period of incapacity relating to the same condition, that also involves:

- Two or more in-person visits to a health care provider or by a nurse or physician's assistant under direct supervision of a health care provider, or by a provider of health care services (e.g. physical therapist) under orders of, or on referral by, a health care provider for treatment within 30 days of the first day of incapacity, unless extenuating circumstances exist. The first visit must be within seven days of the first day of incapacity; or
- At least one in-person visit to a health care provider for treatment within seven days of the first day of incapacity, which results in a regimen of continuing treatment under the supervision of the health care provider. Any incapacity due to pregnancy or prenatal care

B. Any incapacity due to a chronic condition, which is a condition that:

- Requires periodic visits for treatment by a health care provider or by a nurse or physician's assistant under direct supervision of a health care provider at least twice a year; and
- Continues over an extended period of time (including recurring episodes of a single underlying condition); and
- May cause episodic rather than a continuing period of incapacity (e.g. asthma, migraines headaches, diabetes, epilepsy)

C. A period of incapacity which is permanent or long-term due to a condition for which treatment may not be effective, but which requires the continuing supervision of a health care provider (e.g. Alzheimer's disease, terminal states of cancer, severe stroke)

D. Restorative surgery after an accident or other injury; or,

- A condition that would likely result in a period of incapacity of more than three consecutive full calendar days if the employee or employee's family member did not receive treatment

E. Any period of incapacity due to pregnancy including prenatal care

F. Serious Injury or Illness that was incurred in the line of duty on active duty in the Armed Forces

G. Patient requires medical care as a result of organ/bone marrow donation

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 Supporting Information (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
- ☐ Pregnancy

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.

Start Date: _____

☐ This condition began more than one year ago.

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

☐ 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 Schedule leave (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**

PART B - Ability to Work: (Non-Medically based leave requests)

Victim of Family Violence Leave Requests

Please provide a description of the purpose of the leave:

_____

_____

_____

_____

_____

I certify that the information provided in this form is true and correct. Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

_____ _____

Employee Signature **Signature Date**

Victim of Family Violence Only – if this request is to take time to support a victim of family violence, identify the documentation to be submitted:

☐ Signed written statement from applicant certifying that the applicant is taking leave for one of the following reasons:

1. To seek medical care or psychological or other counseling for physical or psychological injury or disability,
2. To obtain services from a victim services organization,
3. To relocate due to such family violence, or
4. To participate in any civil or criminal proceedings related to or resulting from such family violence.

☐ A police or court record related to the family violence; or

☐ A signed written statement that the applicant is a victim of family violence, provided such statement is from an employee or agent of a victim service organization, an attorney, an employee of the Judicial Branch's Office or the Victim Services or the Office of the Victim Advocate, or a licensed medical professional or other licensed professional from whom the applicant sought assistance with respect to family violence. (Must complete Third Party Attestation)

Third Party Attestation for Victim of Family Violence Requests

I attest that I am a/an:

☐ Attorney

☐ Employee of the Judicial Branch's Office of the Victim Services or the Office of the Victim Advocate

☐ Licensed Medical Professional

☐ Other Licensed Professional

I am attesting that the applicant named in this document is a victim of family violence.

_____ _____

Printed Name **Organization Name**

_____ _____

Signature **Signature Date**

Request for bonding, adoption or foster care – if this request is to take time to bond with a child, please provide the following:

Child Name: _____ Child's Birth Date: _____ Child's Placement Date: _____

Attach any of the following documents in support of this bonding request:

☐ Birth Certification ☐ Crib Card ☐ Hospital Discharge Papers confirming birth date

☐ Statement from the Child's Health Care Provider stating the Child's birth date

☐ Statement from the Health Care Provider of the person who gave birth stating the Child's birth date

☐ Confirmation of the placement date for adoption or foster care from one of the following sources:

- Healthcare provider
- Adoption/Foster Care Agency or the CT Department of Children and Families

NOTICE OF CONNECTICUT PAID FAMILY AND MEDICAL LEAVE CLAIM

PART C: TO BE COMPLETED BY YOUR EMPLOYER

1. Date of Hire:

2. Employment Status: ☐ Active ☐ Terminated

If Terminated, provide date of termination

3. Does this employee meet the definition of a Connecticut Employee / Worker? ☐ Yes ☐ No

4. PFML Leave start date:

5. Last date worked:

6. Did employee work a full day? ☐ Yes ☐ No If no, how many hours worked?

7. Is the Employee taking FMLA concurrently with PFL? ☐ Yes ☐ No

8. Leave Type: ☐ Continuous ☐ Reduced Schedule ☐ Intermittent

9. If applicable, please advise if your employee has been approved for CT PFML benefits (not administered by Equitable Financial Life Insurance Company of America) at all in the 12 months preceding the start date of this leave? ☐ Yes ☐ No

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

Note: PFL = Paid Family Leave PML = Paid Medical Leave

LEAVE TYPE	FROM	THROUGH	HOURS APPROVED
PFL - Bond with a Child, Care of Family Member, Caregiver of a Service Member, Military Exigency			
PFL - Right to Leave Work			
PFL - Own Serious Health Condition, Pregnancy, Organ/Bone Marrow Donation			
PML - Absence due to Pre-Partum Pregnancy Incapacity			

11. Normally Scheduled Work Days: ☐ Sun ☐ Mon ☐ Tues ☐ Wed ☐ Thurs ☐ Fri ☐ Sat

12. Normally Scheduled Hours per week: _____

13. For variable work schedules, please provide weekly average of the hours and days worked over the 12 weeks prior to the beginning of the leave period: _____ AVG Weekly Hours _____ AVG Days per week

14. Taxable Percent of Benefit: _____

15. Has the employee applied for, or is receiving, Worker's Compensation or Unemployment payments/benefits?

☐ Yes ☐ No

Earnings and Hours Worked:

16. Please complete the grid below using the following guidance:

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

Base Period means: the first 4 of the last 5 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			

17. Please advise if there are Company Shutdowns scheduled and, if so, provide the dates: _____

18. Are you continuing to pay the employee during this period of disability? ☐ Yes ☐ No

• If yes, please provide dates? _____ Through: _____

NOTE: This excludes any payments that are supplemental in nature (so long as, combined with this benefit, it does not exceed the employee's regular weekly pay).

Completed by: _____ Date: _____

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: