Send completed forms to:
Equitable, EB Claims
8501 IBM Dr, Suite 150-C
Charlotte, NC 28262
Fax Number: (315) 477-2499
ebclaims@equitable.com

EQUITABLE

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

COLORADO FAMILY AND MEDICAL LEAVE INSURANCE (FAMLI)
EMPLOYEE STATEMENT

Part A: Employee Information (to be completed by the employee requesting leave)

1. Employee's Legal Name (First Name, Middle Initial, Last Name)

2. Employee's mailing address (Street Address (including apt/fl #), City, State, Zip)

Street address

City, State Zip

3. Employee's Social Security Number or TIN	4. Employee's Date of Birth (mm/dd/yyyy)	5. Employee's Gender
☐☐☐ - ☐☐ - ☐☐☐☐		☐Male ☐Female ☐Not Designated/Other

6. Employee's Contact Phone #	7. Employee's Contact Email Address
(☐☐☐) ☐☐☐ - ☐☐☐☐ *area code*	

8. Reason for FAMLI Request (choose ONE option)

☐	Medical leave due to my own serious health condition	☐	Qualifying Military Exigency leave
☐	Bond with my new Child	☐	Safe Leave
☐	Care for my Family Member with a serious health condition		

9. The Family Member's Relationship* to the Employee (Claimant) is

☐	Self	☐	Grandparent or Spouse's Grandparent
☐	Spouse	☐	Grandchild
☐	Domestic Partner	☐	Sibling or Spouse's Sibling
☐	Parent	☐	Spouse's Parent
☐	Child(Provide Child's age below) Age (years): _____	☐	Child's Spouse
☐	Individual who has a significant personal bond that is or is like a family relationship, regardless of biological or legal relationship, based on the totality of the circumstances surrounding the relationship (affirm & provide detail in a. and b. below)		

a. I hereby assert that a family-like relationship exists between _____ *(your name)*

and. _____ *(name of person you have a family-like bond with)*

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

_____

_____

Part A Continued on next page.

COLORADO FAMILY AND MEDICAL LEAVE INSURANCE (FAMLI)

EMPLOYEE STATEMENT

Employee Name: _____ Employee SSN: _____

Employee Address: _____

Part A continued from prior page

Part A: Employee Information - Continued from previous page

10. Give the name and details of your last employer. *If you had more than one employer in the past 12 months, name all employers. Wages is your sum total of gross wages in the 12-month period prior to your application for leave, for that employer. Wages should only reflect wages earned in CO employment. Average hours and days worked per week is based off your Regular Work Schedule, averaged from the 4 weeks prior to your last day worked before leave.*

Most Recent CO Employer Business' name, address, and Tax ID #.	Avg # hours worked/week	Avg # hours worked/week	Avg # hours worked/week
Other CO Employer(s) during past 12 mo. Period Business' name, address, and Tax ID #.	Avg # hours worked/week	Avg # hours worked/week	Avg # hours worked/week

11. Will Leave be Utilized Continuously or Intermittently or on a Reduced Leave Schedule? Provide Details Below. Any changes to your leave plans and/or estimated dates, must be communicated/confirmed as soon as possible to us and your employer.

Continuous Leave:

Continuous uninterrupted period of leave for a single qualifying reason.

Leave Start Date
Enter the first date you are requesting continuous leave from work.
☐☐ / ☐☐ / ☐☐☐☐ (month / day / year)

Leave End Date
Enter the last date you are requesting continuous leave through.
☐☐ / ☐☐ / ☐☐☐☐ (month / day / year)

Intermittent Leave:

Leave in separate, non-consecutive time periods rather than a single span of time for a single qualifying reason

Episodic time off

Dates/hour(s) requested:

Reduced Leave Schedule:

A consistent but reduced work schedule for multiple weeks.

Frequency of leave: (eg: 2 days per week, or 4 hours per day, or every Monday)

12. Was 30 days Advanced Notice Given to Your Employer for this Leave?

☐ Yes

Date notice provided to employer (mm/dd/yyyy)

☐ No → Reason:

Part A Continued on next page

Employee Name: _____ Employee SSN: _____

Employee Address: _____

Part A continued from prior page

Part A: Employee Information - Continued from previous page

13. Have you Received or Claimed any of the Following Benefits in the Preceding 52 weeks? Provide Detail Below.

	Benefit Type	received	claimed	from (mm/dd/yyyy)	through (mm/dd/yyyy)
a.	Unemployment benefits	☐	☐		
b.	Workers' Compensation	☐	☐		
c.	FAMLI	☐	☐		
d.	Other (Sick/Vacation/PTO or other employer provided leave. Please specify.)	☐	☐		

Declaration and Signature

NOTICE 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. I further certify that if benefits are paid in excess of the amount to which I am entitled, I will return to the payor of such benefits, the amount that was overpaid, and I acknowledge that failure to do so may result in the accrual of interest and other penalties.

I am hereby making a request for benefits under the Colorado Family and Medical Leave Insurance program. My signature affirms that the information I am providing is true and accurate to the best of my knowledge and belief.

Signature	Date (mm/dd/yyyy)

End of Part A.

Send completed forms to:
Equitable, EB Claims
8501 IBM Dr, Suite 150-C
Charlotte, NC 28262
Fax Number: (315) 477-2499
ebclaims@equitable.com

EQUITABLE

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

COLORADO FAMILY AND MEDICAL LEAVE INSURANCE (FAMLI)
EMPLOYER STATEMENT

Employee's Legal Name:		Employee's SSN:	
Employee's Mailing Address:			

Part B: Employer Information (to be completed by the employer for the above named employee requesting FAMLI)

1. Business's full legal name and mailing address
Business name (including any DBA or Trade Name)

Street address

City, State Zip

2. Business's Federal Employer Identification Number (FEIN)
☐☐ - ☐☐☐☐☐☐☐

3. Employer contact person (Name & Title) for this leave request

4. Employer's contact phone #
(☐☐☐) ☐☐☐ - ☐☐☐☐ Ext _____
area code

5. Employer contact email address

6. Employee's hire date
☐☐ / ☐☐ / ☐☐☐☐
month *day* *year*

7. Employee's current employment status
☐ Actively employed-not terminated
☐ Terminated from employment
Date termed: _____ *(mm/dd/yyyy)*

8. Last day worked before leave
☐☐ / ☐☐ / ☐☐☐☐
month *day* *year*

9. Has the employee returned to work?
☐ Yes ☐ No
Return to work date: _____
☐Actual ☐Estimated *(mm/dd/yyyy)*

10. Colorado ("CO") employment verification

a. Are the employee's earnings reported at year end on IRS form W-2? ☐ Yes ☐ No (answer question 10b.)
b. Is the employee subject to Unemployment Insurance obligations in CO? ☐ Yes ☐ No (answer question 10c.)
c. Is the employee's service localized (performed entirely) within CO? ☐ Yes ☐ No (answer question 10d.)
d. If services are not localized, is the employee's base of operations in CO, and some of the work is performed in CO? ☐ Yes ☐ No (answer question 10e.)
e. If there is no base of operations, does the employee perform some of the services within CO and receive direction and control from CO? ☐ Yes ☐ No (answer question 10f.)
f. If there is no place of direction and control, no localized services and no base of operations in CO, does the employee reside in CO? ☐ Yes ☐ No

Part B continues on next page.

COLORADO FAMILY AND MEDICAL LEAVE INSURANCE (FAMLI)
EMPLOYER STATEMENT

Employee's Legal Name:		Employee's SSN:	
Employee's Mailing Address:			

Part B: Employer Information - Continued from previous page

11. Employee's job title

12. Select the days of the week the employee usually works

☐ Mon ☐ Tues ☐ Wed ☐ Thur ☐ Fri ☐ Sat ☐ Sun

13. Provide the employee's earnings history for the prior 4 completed calendar quarters preceding the request for leave

Quarter Ending (mm/yyyy)	Gross Wages ($)

Average

14. Provide the scheduled work hours from the last 4 weeks the employee reported to work prior to the last day worked before leave

Week #	Scheduled Weekly Hours Worked (e.g. 40 hours)
Week 1	
Week 2	
Week 3	
Week 4	
Average	

15. Will Leave be Utilized Continuously or Intermittently or on a Reduced Leave Schedule? Provide Details Below. Any changes to your employee's leave plans and/or estimated dates, must be communicated/confirmed as soon as possible to us.

Continuous Leave:

continuous uninterrupted period of leave for a single qualifying reason.

Leave Start Date
Enter the first date you are requesting continuous leave from work.
☐☐ / ☐☐ / ☐☐☐☐ (month / day / year)

Leave End Date
Enter the last date you are requesting continuous leave through.
☐☐ / ☐☐ / ☐☐☐☐ (month / day / year)

Intermittent Leave:

Leave in separate, non-consecutive time periods rather than a single span of time for a single qualifying reason

Episodic time off

Dates requested:

Reduced Leave Schedule:

A consistent but reduced work schedule for multiple weeks.

Frequency of leave: (eg: 2 days per week, or 4 hours per day, or every Monday)

16. Was 30 days advance given to you by the employee requesting foreseeable leave?

☐ Yes ☐ No

Date notice provided to employer (mm/dd/yyyy)
Detail:

Will the employer waive the 30 day advance notice requirement for a foreseeable leave?
☐ Yes ☐ No

Part B continues on next page.

COLORADO FAMILY AND MEDICAL LEAVE INSURANCE (FAMLI)
EMPLOYER STATEMENT

Employee's Legal Name:		Employee's SSN:	
Employee's Mailing Address:			

Part B continued from prior page

Part B: Employer Information - Continued from previous page

17. Has the employee received or claimed any of the following benefits in the preceding 52 weeks?
Provide detail below, and any supporting documentation pertaining to the type of benefit received/claimed.

	Benefit Type	received	claimed	from (mm/dd/yyyy)	through (mm/dd/yyyy)
a.	Unemployment benefits (CESA)	☐	☐		
b.	Workers' Compensation due to work-related injury/illness	☐	☐		
c.	FAMLI	☐	☐		
d.	Other (Sick/Vacation/PTO or other employer provided leave. Please specify. Attach a separate sheet if necessary)	☐	☐		

18. Employer-provided Paid Leave
Will the employee be using any employer-provided paid leave during the leave period requested? ☐ Yes ☐ No
If yes, provide details on the number of hours the employee has available, and list the date(s) this paid time off is applicable for.
Number of hours: _____ Start date: _____ (mm/dd/yyyy) End date: _____ (mm/dd/yyyy)
Are you requesting reimbursement for advance payment of FAMLI benefits? ☐ Yes ☐ No

Note, employer reimbursement is not permitted for any period where the employee is using ACCRUED time to receive full salary (Ex. Sick/Vacation/PTO). Employer reimbursement may be permitted if the employee's salary is being continued through a salary continuation program or other employer-provided leave program (eg. Parental leave).

19. Is the employee taking FMLA concurrently with this leave?
☐ Yes ☐ No

20. CO FAMLI Policy #:

Declaration and Signature

NOTICE 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. I am the person authorized to sign as the employer of the employee requesting benefits under the Colorado Family and Medical Leave Insurance program. My signature affirms that to the best of my knowledge the information I have provided is true, accurate, and complete. Any false statements or other failure to provide truthful, accurate and complete information may result in monetary and other penalties as well as the possibility of criminal prosecution.

Signature Date:

End of Part B.

EQUITABLE

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

COLORADO FAMILY AND MEDICAL LEAVE INSURANCE (FAMLI)
HEALTH CARE PROVIDER CERTIFICATION EMPLOYEE'S OWN HEALTH CONDITION

Employer/Carrier Name:	Equitable Financial Life Insurance Company of America	Phone:	(866) 274-9887
		Fax:	(315) 477-2499
Address:	Equitable, EB Claims, 8501 IBM Dr, Suite 150-C, Charlotte, NC 28262	Email:	ebclaims@equitable.com
		Portal:	equitable.com

Important tips when completing this form:

To request Colorado FAMLI benefits, you will need to return this medical certification form. To start, complete Section 1 and send it to your treating healthcare provider to complete Section 2 and return to Equitable with your Application and any other supporting documents as part of your claim for benefits.

Section 1: For Completion by the Employee

First Name	Last Name	Date of Birth	Last 4 Digits of SSN	Claim Number (if available)

Address, City, State, Zip Code

Cell number	Home Number	Work Number

Section 2: For Completion by the Treating Health Care Provider

Your patient made a request to be absent from work because of their own illness or injury. For us to make a decision on their claim for CO FAMLI benefits, we will need you to complete the information in Section 2. When completing this certification, we ask.

- Your answers are to be your best estimate based on your medical knowledge, experience, and examination of the patient.
- Be as specific as you can. Using terms like "as needed", "unknown" or "indeterminate" may not be enough to approve the claim._____
- Limit your responses to the health condition for which your patient is seeking leave. If your patient needs leave due to more than one health condition, please complete a separate certification for each condition:
- Do not include information about genetic tests, as defined in 29 C.F.R. § 1635.3(f), genetic services, as defined in 29 C.F.R. § 1635.3(e), or the manifestation of disease or disorder in the employee's family members, 29 C.F.R. §1635.3(b).

Check the box(es) for the questions below, as applicable.

☐ Inpatient Care: The patient (☐ was / ☐ is/ ☐ will be) admitted for an overnight stay in a hospital, hospice, or residential medical care facility on the following date(s):

☐ Incapacity plus Treatment: (e.g. outpatient surgery, strep throat)

- Due to the patient's health condition, the patient (☐ was / ☐ is/ ☐ will be) incapacitated for *more than three consecutive, full calendar days.*
- The patient (☐ was / ☐ is/ ☐ will be) seen on the following date(s):_____
- The health condition (☐ had / ☐ has/ ☐ will) also result(ed) in a course of continuing treatment under the supervision of a health care provider *(e.g., prescription medication (other than over the counter), therapy requiring special equipment, etc.)*

Continued on next page

COLORADO FAMILY AND MEDICAL LEAVE INSURANCE (FAMLI)

HEALTH CARE PROVIDER CERTIFICATION EMPLOYEE'S OWN HEALTH CONDITION

Employee's Name	Date of Birth	Claim Number (if known)

Section 2: For Completion by the Treating Health Care Provider (continued)

Continued from previous page

☐ Pregnancy: The health condition is pregnancy. List the expected delivery date: _____ (mm/dd/yyyy)

- Is this a pregnancy or childbirth complication? ☐ Yes ☐ No

☐ Chronic Health Conditions: (e.g., asthma, migraine headaches) Treatment visits are expected to be at least twice per year

☐ Permanent or Long-Term Health Conditions: Due to the health condition, incapacity is permanent or long term and requires the continuing supervision of a health care provider (even if active treatment is not being provided).

☐ Health Conditions requiring Multiple Treatments: (e.g., chemotherapy treatments, restorative surgery, etc.) Due to the health condition, it is medically necessary for the patient to receive multiple treatments.

☐ None of the above: If none of the above six categories is checked, (i.e., inpatient care, pregnancy) no additional information is needed. Please sign and date the form.

Date health condition commenced:

_____

Date you first examined the patient for this health condition: _____

Last office visit: _____

Next office visit: _____

Provide your best estimate of how long the health condition lasted or will last:

_____

For the health condition for which your patient is requesting time away from work, is it your belief that the health condition was caused by or otherwise related to a workplace injury or illness?

☐ Yes

☐ No

If the employer does not supply a statement of your patient's essential functions or a job description, answer these questions based upon the patient's own description of the essential job functions. An employee who must be absent from work to receive medical treatment(s), such as scheduled medical visits, for a health condition is considered to be not able to perform the essential job functions of the position during the absence for treatment(s).

Due to the health condition, my patient (□ was not able / □ is not able / □ will not be able) to perform one or more of the essential job function(s). Identify at least one essential job function your patient was/is/will be unable to perform.

Provide the relevant medical facts relating to the health condition requiring this leave (these facts may include diagnosis, symptoms, or any regimen of continuing treatment such as the use of specialized equipment):

Continued on next page

COLORADO FAMILY AND MEDICAL LEAVE INSURANCE (FAMLI)

HEALTH CARE PROVIDER CERTIFICATION EMPLOYEE'S OWN HEALTH CONDITION

Employee's Name	Date of Birth	Claim Number (if known)

Section 2: For Completion by the Treating Health Care Provider (continued)

Check the applicable box(es) and complete the information that best describes the type of time away from work that the applicant will need for their own health condition.

☐ Continuous leave

My patient has/will be incapacitated for a single continuous period due to their own health condition, including time for treatment and recovery beginning _____/_____/_____ and ending _____/_____/_____

☐ Reduced Work Schedule leave

My patient will need to work a reduced work schedule due to their own health condition and associated treatment and recovery period beginning_____/_____/_____ and ending _____/_____/_____

Patient's work capacity is up to _____ hours per week

☐ Intermittent leave

My patient is expected to have periodic flare-ups or follow-up treatment appointments where intermittent absence from work will be medically necessary beginning _____/_____/_____ and ending _____/_____/_____

Patient's incapacity may occur up to _____ hours per week.

Designated Representative

First Name	Last Name	Relationship to the Employee

Address, City, State, Zip Code

Cell Number	Home Number	Work Number

Health Care Provider Information and Signature

Print Treating Health Care Provider Name:	Specialty/Board Certification:

Treating Health Care Provider's Business address *(Include County if practicing in Colorado):*

Certification License number and State:	NPI number *(Required if practicing outside of Colorado):*

Telephone:	Fax Number:	Email Address:

Treating Health Care Provider Signature: 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 _____ 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: