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 FAMILY MEMBER'S HEALTH CONDITION

Employer/Carrier Name:	Equitable Financial Life Insurance Company of America	Phon:	(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 the process, complete Sections 1 and 2, and send it to your family member's treating healthcare provider to complete Section 3 and return to Equitable with your Application and any other supporting documents as part of your claim for benefits.

Section 1: Employee Information

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

Address, City, State, Zip Code

Cell number	Home Number	Work Number

Section 2: About the Family Member

Select The Family Member's Relationship to You:

☐Child (of any age) ☐ Spouse ☐ Domestic Partner ☐Parent or your Spouse/Domestic Partner's Parent
☐Grandparent or your Spouse/Domestic Partner's Grandparent
☐Grandchild or your Spouse/Domestic Partner's Grandchild
☐Sibling or your Spouse/Domestic Partner's Sibling
☐Person with whom you have a significant bond that is or is like a family relationship

First Name	Last Name	Date of Birth

Address, City, State, Zip Code

Section 3: For Completion by the Family Member's Treating Health Care Provider

A family member of your patient has made a request to be absent from work to care for your patient. For us to make a decision on the employee's claim for CO FAMLI benefits for the care of your patient, we will need you to complete the information in Section 3. When completing this certification, we ask:

- Your answers are to your best estimate based on your medical knowledge, experience, and examination of your 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 patient's health condition for which the employee is seeking benefits.
- 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).

Continued on next page

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Fax Number: (315) 477-2499
ebclaims@equitable.com

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

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

Section 3: For Completion by the Family Member's Treating Health Care Provider (continued)

Patient's Name: _____

Continued from previous page.

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

☐ Inpatient Care: The patient (☐ has been / ☐ is expected to 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 health condition, the patient (☐ has been / ☐ is expected to be) incapacitated for more than three consecutive, full calendar days.
- The patient (☐ was / ☐ will be) seen on the following date(s): _____
- The health condition (☐ has / ☐ has not) also resulted in a course of continuing treatment under the supervision of a health care provider (e.g., prescription medication (other than over the counter) or therapy requiring special equipment)

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

☐ 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) 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, (e.g., 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: _____

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):

To qualify for benefits, care of the patient must be medically necessary. Briefly describe the type of care needed by the patient (e.g., assistance with basic medical, hygienic, nutritional, safety, transportation needs, physical care, or psychological comfort).

Continued on next page

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

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

Section 3: For Completion by the Family Member's 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 employee will need to care for your patient.

☐ Continuous leave

Due to the health condition and associated treatment and recovery, it was/is/will be necessary for the employee to be absent from work to provide care for my patient for the continuous period beginning ___/___/____ and ending ___/___/____.

☐ Reduced Work Schedule

Due to the health condition and associated treatment and recovery, it was/is/will be necessary for the employee to be absent from work to provide care for my patient beginning ___/___/____ and ending ___/___/____.

It is necessary for the employee to provide care for my patient for _____ hours per week.

☐ Intermittent leave:

Due to the health condition, my patient is expected to have periodic flare-ups or follow-up treatment appointments and it was/is/will be necessary for the employee to be absent from work to provide care for my patient beginning ___/___/____ and ending ____/____/_____.

It is necessary for the employee to provide care for my patient for _____ hours per week.

Treating 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:

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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.

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COLORADO FAMILY AND MEDICAL LEAVE INSURANCE (FAMLI)

SAFE LEAVE ATTESTATION AND LEAVE REQUEST

Employer/ Carrier Name: Equitable Financial Life Insurance Company of America

Address: 8501 IBM Dr, Suite 150-C, Charlotte, NC 28262

Phone: (866) 274-9887

Fax: (315) 477-2499

Email: ebclaims@equitable.com

Portal: equitable.com

Important directions for completing your request for benefits:

To request benefits under Colorado FAMLI, 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.

Section 1: Employee/Applicant Information

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

Address, City, State, Zip Code

Cell number	Home Number	Work Number

Section 2: Attestation of Need for Safe Leave

"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: _____ Relationship to me: _____

Employee 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: