



EQUITABLE

Equitable Financial Life Insurance Company of America

For Assistance Call (866) 274-9887

COLORADO FAMILY AND MEDICAL LEAVE INSURANCE (FAMLI)

SAFE LEAVE ATTESTATION AND LEAVE REQUEST

Employer/ Equitable Financial Life Insurance Company of
Carrier Name: 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)
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Address, City, State, Zip Code

Cell number	Home Number	Work Number
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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: _____

Equitable is the brand name of the retirement and protection subsidiaries of Equitable Holdings, Inc., including Equitable Financial Life Insurance Company (NY, NY); Equitable Financial Life Insurance Company of America, an AZ stock company with an administrative office located in Charlotte, NC; and Equitable Distributors, LLC. The obligations of Equitable Financial Life Insurance Company and Equitable Financial Life Insurance Company of America are backed solely by their claims-paying abilities.

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**

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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			
<i>Business name (including any DBA or Trade Name)</i>			
<i>Street address</i>			
<i>City, State Zip</i>			
2. Business's Federal Employer Identification Number FEIN)		3. Employer contact person (Name & Title) for this leave request	
4. Employer's contact phone #		5. Employer contact email address	
6. Employee's hire date		7. Employee's current employment status	
month day year		☐ Actively employed-not terminated ☐ Terminated from employment Date termed: _____(mm/dd/yyyy)	
8. Last day worked before leave		9. Has the employee returned to work?	
/ / year month day year		☐ Yes ☐ No Return to work date: _____ ☐ Actual ☐ Estimated	
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.

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**COLORADO FAMILY AND MEDICAL LEAVE INSURANCE (FAMLI)
EMPLOYER STATEMENT**

Employee's Legal Name:		Employee's SSN:	
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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 **Scheduled number of hours worked per week: _____
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13. Taxability Information
 What percentage, if any, do you contribute towards the cost of the FAMLI premium? _____%
 Does the employee contribute towards the cost of the FAMLI premium? ☐ Yes ☐ No
 If yes, what percent? _____% Is it on a ☐ Pre or ☐ Post tax basis?
 What percent of this employee's FAMLI benefit is taxable? _____%
Note: Paid Family Leave benefits will be treated as 100% taxable and not subject to Federal withholding including Social Security, Medicare and Federal Income Tax.

14. Provide the employee's earnings history for the prior 5 completed calendar quarters preceding the request for leave	15. Provide the actual hours worked from the last 4 weeks the employee reported to work prior to the last day worked before leave																						
<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <th style="width: 30%;">Quarter Ending (mm/yyyy)</th> <th style="width: 70%;">Gross Wages (\$)</th> </tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> </table>	Quarter Ending (mm/yyyy)	Gross Wages (\$)											<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <th style="width: 50%;">Week #</th> <th style="width: 50%;">Scheduled Weekly Hours Worked</th> </tr> <tr><td>Week 1</td><td> </td></tr> <tr><td>Week 2</td><td> </td></tr> <tr><td>Week 3</td><td> </td></tr> <tr><td>Week 4</td><td> </td></tr> </table>	Week #	Scheduled Weekly Hours Worked	Week 1		Week 2		Week 3		Week 4	
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16. 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: <i>continuous uninterrupted period of leave for a single qualifying reason.</i>	Leave Start Date Enter the first date you are requesting continuous leave from work. / / / / / / monthdayyearmonthdayyear Leave End Date Enter the last date you are requesting continuous leave through. / / / / / monthdayyearmonthdayyear
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Intermittent Leave: <i>Leave in separate, non-consecutive time periods rather than a single span of time for a single qualifying reason</i> <i>Episodic time off</i>	Dates requested:
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Reduced Leave Schedule: <i>A consistent but reduced work schedule for multiple weeks.</i>	Frequency of leave: (eg: 2 days per week, or 4 hours per day, or every Monday)
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**COLORADO FAMILY AND MEDICAL LEAVE INSURANCE (FAMLI)
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Employee's Legal Name:		Employee's SSN:	
Employee's Mailing Address:			

Part B: Employer Information - Continued from previous page

17. 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?

b. Yes ☐ No ☐

18. Has the employee received or claimed any CO FAMLI benefits in the preceding 52 weeks?

Benefit Type	received	claimed	from (mm/dd/yyyy)	through (mm/dd/yyyy)
a. FAMLI	☐	☐		
	☐	☐		
	☐	☐		

19. Does the employee expect to use or receive any other of the following benefits during the requested CO FAMLI leave?

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

20. 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: _____ End date: _____
(mm/dd/yyyy) (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).

Part B continues on next page.

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Employee's Legal Name:		Employee's SSN:	
Employee's Mailing Address:			
Part B: Employer Information - Continued from previous page			
21. Is the employee taking FMLA concurrently with this leave? ☐ Yes ☐ No			
22. CO FAMLI Policy #: 			
<u>Declaration and Signature</u> 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 (mm/dd/yyyy)

End of Part B.

Electronic Funds Transfer (EFT) Request 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:

Account Number: _____

Saving:

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 have the 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 and/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: