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

# Connecticut Paid Leave
# Connecticut Paid Family and Medical Leave for Leave for Child Bonding (CT PL) Application Checklist

The Connecticut Paid Family Leave (CT PFL) program presents the opportunity for you to receive income-replacement benefits while you take time away from work to take care of yourself and your family's health needs. To apply for these benefits, you must tell us the reason you are applying for benefits and provide documentation supporting the leave reason as well as documentation verifying your identity.

## Use this form if you are starting or expanding my family

You are bonding with a new addition to your family; by birth, adoption, or foster care. You may also be eligible to receive income-replacement benefits for absences associated with pre-placement activities, such as court appointments, traveling, etc.

You must complete and submit the following:

- **Bonding Statement** form, and a copy of the *bonding documentation* listed in the Bonding Statement.
- **Statement of Family Relationship** form
- **Documentation of Parental Relationship** form

## Employment Verification

In order to support your Paid Leave request, you must have your employer complete the following:

- **Employment Verification** form
- **Employer Wage Verification** form

If you have more than one employer, each employer should complete the forms on your behalf.

## Electronic Funds Transfer - optional

You have the option to have benefit payment deposited into your account. This is optional, if you do not submit the request form, any benefits will be paid via a check mailed to you.

- **Electronic Funds Transfer (EFT) Request** form

**CT PFL Application Document Checklist – continued on next page**

## Identity Verification

In order to support your Paid Leave request, you must provide identification verification documents with your application. Please submit one stand-alone document OR two alternate documents. **Do not send original documents.**

Stand-alone documents:

The easiest way to provide proof of identity is a color copy of your Connecticut driver's license or ID. If you don't have a Connecticut driver's license or ID, you will need to provide **ONE** of the following documents for ID proofing:

☐ Valid United States government (federal or state) issued form of identification (i.e., passport, passport card, ID card, enhanced or standard driver's license)

☐ Valid United States Citizenship and Immigration Service ID.

- Form I-766 Employment Authorization
- Form I-551 Permanent Resident Card

☐ Valid foreign government issued form of identification (i.e., passport, consular ID card, national identification card)

### Alternate documents:

Please provide one of the documents from Column A and one of the documents from Column B.

| Column A | Column B |
|---|---|
| ☐ A certified copy of your birth certificate filed with a State Office of Vital Statistics or equivalent agency in your state of birth.<br>☐ A certificate of Citizenship, Form N-560, or Form N-561, issued by DHS<br>☐ A certificate of Naturalization (Form N-550 or Form N-570) | ☐ An SSN Card<br>☐ A W-2 Form<br>☐ An SSA-1099 Form<br>☐ A Non-SSA-1099 Form<br>☐ A pay stub with your full name and SSN on it<br>☐ An authorization letter from the IRS displaying your 9-digit individual tax identification number |

## Where do I send my application?

| | |
|---|---|
| Equitable, EB Claims | Phone: (866) 274-9887 |
| 8501 IBM Dr, Suite 150-C | Fax: (315) 477-2499 |
| Charlotte, NC 28262 | Email: ebclaims@equitable.com |

**Under penalties of perjury, I declare that to the best of my knowledge and belief, the information contained herein is true, correct, 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. I further certify that if benefits are paid in excess of the amount to which I am entitled, I will return to the Authority the amount that was overpaid, and I acknowledge that failure to do so may result in the accrual of interest and other penalties**.

| Signature: | Date: |
|---|---|
| | |

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# Connecticut Paid Leave Bonding Statement

| | |
|---|---|
| **Send completed form to:**<br>Equitable, EB Claims<br>8501 IBM Dr, Suite 150-C<br>Charlotte, NC 28262 | Phone: (866) 274-9887<br>Fax: (315) 477-2499<br>Email: ebclaims@equitable.com |

## Applicant Information

| | |
|---|---|
| Applicant Name:<br>*first* *middle* *last* | Case Number (if known): |

| | | | | |
|---|---|---|---|---|
| List other last names (if any), under which applicant has worked:<br>First Name: | Middle Name: | Last Name: | Last 4 Digits of SSN: | Date of Birth: |

Address:

Street City State Zip Code

| | |
|---|---|
| Cell Phone: | Email: |

**I consent to receiving ☐ cell phone ☐ email communications from Equitable** related to my claim(s) at the email address and/or cell phone number provided above.

## Bonding Statement (Statement of the family relationship to be completed by employee)

I am asserting that I am making a request for paid family leave benefits to bond with:

☐ Biological child - Please provide documentation as requested below.
☐ Adopted child - Please provide documentation as requested below.
☐ Foster child - Please provide documentation as requested below.

## Bonding Documentation (to be completed by the employee)

Please attach a copy of the appropriate documentation to this statement.

☐ Biological child - Copy of Hospital Discharge document, Birth Certificate or the completed Certification of Birth Form.
☐ Adopted child - Please provide a copy of adoption papers or court documents, child's date of birth and adoption date.
☐ Foster child - Please provide a copy of child's foster care papers or a court document, child's date of birth and date(s) of placement.

**Under penalties of perjury, I declare that to the best of my knowledge and belief, the information contained herein is true, correct, 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. I further certify that if benefits are paid in excess of the amount to which I am entitled, I will return to the Authority the amount that was overpaid, and I acknowledge that failure to do so may result in the accrual of interest and other penalties.**

| | |
|---|---|
| Signature: | Date: |

**Connecticut Paid Family Leave (CT PFL)**
**Statement of Family Relationship**

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**Send completed form to:**

Equitable, EB Claims
8501 IBM Dr, Suite 150-C
Charlotte, NC 28262

Phone: (866)274-9887
Fax: (315)477-2499
Email: ebclaims@equitable.com

## Applicant Information

| First Name: | Middle Name: | Last Name: | Case Number: |
|---|---|---|---|
| List other last names (if any), under which applicant has worked: | | Last 4 Digits of SSN: | Date of Birth: |
| Street Address: | | | |
| City: | | State: | Zip: |
| Cell Phone: | Home Phone: | | Work Phone: |

## Relationship:

I am seeking paid leave benefits in connection with leave to care for a family member with a serious health condition. The family member is my:

☐Spouse
- ☐ Domestic Partner
- ☐ Domestic partner's grandparent
- ☐ Grandparent's domestic partner
- ☐ Grandchild's domestic partner
- ☐ Domestic partner's grandchild

☐ Sibling
☐ Sibling-in-law
☐ Stepsibling
☐ Child

☐ Stepchild
☐ Grandparent
☐ Spouse's grandparent
☐ Grandparent's spouse
☐ Grandchild

☐ Spouse's grandchild
☐ Grandchild's spouse
☐ Parent
☐ Parent-in-law
☐ Stepparent

or

☐ An individual related to me by blood or affinity whose close association with me is the equivalent to one of the listed family relationships.

**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 exists between myself and _____

(Applicant to insert name of affinity relationship individual)

**Please describe how this relationship demonstrates a family relationship:**

_____

_____

_____

*CT PFL Statement of Family Relationship – continued in next page*

## Connecticut Paid Leave (CT PFL)
## Statement of Family Relationship - continued

*CT PFL Statement of Family Relationship – continued from prior page*

**Relationship: - continued from prior page**

**Under penalties of perjury, I declare that to the best of my knowledge and belief, the information contained herein is true, correct, 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. I further certify that if benefits are paid in excess of the amount to which I am entitled, I will return to the Authority the amount that was overpaid, and I acknowledge that failure to do so may result in the accrual of interest and other penalties.**

| **Signature:** | **Date:** |
|---|---|
| | |

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# Connecticut Paid Leave
# Documentation of Parental Relationship

| | |
|---|---|
| Send completed form to: Equitable, EB Claims<br>8501 IBM Dr, Suite 150-C<br>Charlotte, NC 28262 | Phone: (866) 274-9887<br>Fax: (315) 477-2499<br>Email: ebclaims@equitable.com |

## Applicant Information

| | |
|---|---|
| Applicant Name:<br>*first* *middle* *last* | Case Number (if known): |

If you are applying for income replacement benefits to bond with your new-born child(ren), you must provide documentation showing your child(ren)'s date of birth and your relationship to the child(ren).
Documentation can include any one of the following documents

- A copy of your child(ren)'s birth certificate(s);
- A copy of the hospital discharge statement showing your child(ren)'s date of birth (documentation provided must include your name on it), or

This form completed and signed by a healthcare provider.

**Instructions:**

1. Provide the name and date of birth of any parent who is seeking paid leave benefits for bonding.
2. Have a healthcare provider complete and sign the certification of birth section.
3. Documentation is required for each family leave application.

## Parent's Information (To be completed by the parent(s) applying for leave)

**Information about the parent(s) requesting bonding leave:**

| | | | |
|---|---|---|---|
| First Name: | Last Name: | Last 4 Digits of SSN: | Date of Birth: |
| First Name: | Last Name: | Last 4 Digits of SSN: | Date of Birth: |

## Certification of Birth (To be completed by the health care provider. Please be sure to sign the form.)

| | | |
|---|---|---|
| Child(ren)'s date of birth: | Place of birth (city, state): | Gender(s):<br>☐ Male ☐ Female ☐ X ☐ Prefer not to answer |

## Health Care Provider Information

Health Care Provider's Name:
*first* *middle* *last*

Health Care Provider's Business Address:

| | | |
|---|---|---|
| City: | State: | Zip Code: |

**Continued on next page**

**Connecticut Paid Leave (CT PL)**

## Documentation of Parental Relationship (continued)

| | | |
|---|---|---|
| Type of Practice/Medical Specialty: | | |
| Certificate license number and state: | | |
| Telephone: | Fax: | Email: |

**Under penalties of perjury, I declare that to the best of my knowledge and belief, the information contained herein is true, correct, 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.**

| | |
|---|---|
| Health Care Provider Signature & Credentials | Date |

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# CONNECTICUT PAID FAMILY LEAVE (CT PFL) EMPLOYMENT VERIFICATION

**Instructions to the employer:** Please complete the following information and return to Equitable within 10 calendar days of receipt of this form. You can send it by email ebclaims@equitable.com or fax: (315) 477 2499.

**Send completed form to:**
Equitable, EB Claims
8501 IBM Dr, Suite 150-C
Charlotte, NC 28262

Phone: (866) 274-9887
Fax: (315) 477-2499
Email: ebclaims@equitable.com

## Section 1: Applicant's Leave Information (to be completed by the applicant or employer)

| First Name: | Middle Name: | Last Name: | Date of Birth: |
|---|---|---|---|
| Last 4 digits of SSN: | Beginning Date of Leave: | End Date of Leave: | |
| Leave Type: ☐ Continuous ☐ Intermittent ☐ Reduced Schedule | | Case Number (if known): | |

Reason for Leave: ☐ Employee's own serious health condition ☐ Caregiver leave ☐ Bonding leave ☐ Military caregiver leave ☐ Qualifying exigence leave ☐ Family violence leave

## Section 2: Employer Information (to be completed by the employer)

| Employee Name: | | |
|---|---|---|
| Address: | | |
| City: | State: | Zip Code: |
| Contact Name: | FEIN: | |
| Contact Phone Number: | Contact Email: | |

If one of the following categories is applicable, check the appropriate box and return the form to Equitable without completing the remaining sections of the form:
☐ Federal Government ☐ Railroad ☐ Private Elementary or Secondary School
☐ Government of another state ☐ Non-contributing employee of a Municipality, Board of Education or Sovereign Nation ☐ Non-contributing employee of CT State Government

## Section 3: Applicant's Income and Work Schedule (to be completed by the employer. If the employee is not taking paid leave with this employer, please only complete sections 1-3, section 7 and submit back to Equitable.)

| Employee's Rate of Pay (e.g., 13/hour or $800/week): | Employee's Hire Date: | Date of employee's separation from employment (if applicable): |
|---|---|---|

Please select the workdays that the employee typically works
☐ Sunday ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday

A "workweek" is the employee's usual or normal schedule (hours per week). If the employee has a standard workweek (e.g., 40 hours/week, or 24 hours/week) please provide that schedule:

***CT PFL Employment Verification Continued on next page.***

## CONNECTICUT PAID FAMILY LEAVE (CT PFL)
## EMPLOYMENT VERIFICATION

*CT PFL Employment Verification continued from prior page*

**Section 3: Applicant's Income and Work Schedule** (to be completed by the employer. If the employee is not taking paid leave with this employer, please only complete sections 1-3, section 7 and submit back to Equitable.) - continued

If the employee's workweek varies from week to week, please state the hours worked in each of the 12 weeks prior to the receipt of this form or prior to the start of leave, whichever occurs first (including any overtime worked), plus any hours for which the employee took any paid time off:

| | | | |
|---|---|---|---|
| Week 1: | Week 2: | Week 3: | Week 4: |
| Week 5: | Week 6: | Week 7: | Week 8: |
| Week 9: | Week 10: | Week 11: | Week 12: |

**Section 4: Scheduled Closures** (to be completed by the Employer)

For the requested leave period, please provide the specific dates of any Company holidays or other scheduled closures or shutdowns during which the employee would not ordinarily be expected to work if not on leave:

| Applicant's First Name: | Applicant's Middle Name: | Applicant's Last Name: | Case Number (if known): |
|---|---|---|---|
| | | | |

**Section 5: Other Potential Sources of Income** (to be completed by the Employer)

Has the employee applied for Worker's Compensation benefits? ☐ Yes ☐ No
If Yes, have the Worker's Compensation benefits been approved? ☐ Yes ☐ No
If Yes, please indicate the dates for which the employee is approved to receive Worker's Compensation Benefits:
To:_____ From: _____*(mm/dd/yyyy)*.

**"Income-replacement benefits"** refers to employer-provided sources of income to the employee, including sick leave, vacation leave, paid time off, disability benefits, etc. **Please indicate which of the following applies to the employee (please check all that apply and at least one option must be selected):**

☐ Employee will not receive any employer-provided income-replacement benefits while on leave.

☐ Employee will receive employer-provided income-replacement benefits equal to the employee's regular wages for the entire duration of the employee's leave.

☐ Employee will receive employer-provided income-replacement benefits that are equal to the employee's regular wages for a portion of the employee's leave.
Please indicate the last date the employee will stop receiving such income-replacement benefits:
_____

**CONNECTICUT PAID FAMILY LEAVE (CT PFL)**

**EMPLOYMENT VERIFICATION**

*CT PFL Employment Verification continued from prior page*

## Section 5: Other Potential Sources of Income (to be completed by the Employer) - continued

☐ Employee will receive employer-provided income-replacement benefits that are less than the employee's regular wages for some or all of the employee's leave.
Please indicate if the employer-provided income-replacement benefits are:
☐ **primary** - the benefit payment duration and amount will be the same whether or not CT PFL benefits are payable
☐ **secondary** – the benefit payment will be delayed or reduced if CT PFL benefits are payable

If the employer-provided income-replacement benefits are primary, what percentage of the employee's wages will be paid and for how long? Percentage: _____Duration: _____
If the employer-provided income-replacement benefits are primary and the percentage will change over time, please indicate separate percentages on each line below as applicable:

Percentage:_____ Duration:
Percentage: _____ Duration:

*If the income-replacement benefits are secondary, CT Paid Family Leave delegates to the employer the responsibility for complying with the statutory requirement that the sum of the CT Paid Family Leave benefits plus employer-provided benefits does not exceed 100% of the employee's regular wages.*

## Section 6: Leaves Requiring Additional Employer Approval (to be completed by the Employer)

**Complete only if Intermittent or Reduced Schedule Bonding Leave is requested by the employee:**
Have you approved your employee to take intermittent leave or reduced schedule leave for the purpose of bonding with a newborn or newly adopted child or newly placed foster child? ☐ Yes ☐ No

If **Yes**, please describe the timing, frequency and duration of intermittent leave or change in schedule (e.g., leave taken 2 days/month, schedule reduced by 15%):

**Complete only if Qualifying Exigency Leave for an "other approved reason" is requested by the employee:**
Have you approved your employee to take qualifying exigency leave for a reason other than leave to address short-notice deployment, military events and related activities, emergency childcare or parental care, financial and legal arrangements, counselling, covered servicemember's rest and recuperation, post-deployment activities? ☐ Yes ☐ No

If **Yes**, please describe the timing, frequency and duration of such qualifying exigency leave, (e.g., leave taken 2 days/month, schedule reduced by 15%):

## Section 7: Employer Declaration and Signature

| | |
|---|---|
| **Employee Signature** | **Date:** |
| **Printed Name:** | **Title:** |

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# Connecticut Paid Leave
# Employer Wage Verification

**Instructions to the employer:** Please complete the following information and return to Equitable within **10 calendar days** of receipt of this form.
You can send it by email **ebclaims@equitable.com** or fax to **(315) 477-2499**.
This form is intended to **verify wages when wage data is unavailable from CT Department of Labor.**

## Section 1: Applicant's Information

| Applicant Name: *first* *middle* *last* | Case Number (if known): |
|---|---|

| Date of Birth: | Case Number (if known): | Leave Start Date: |
|---|---|---|

## Section 2: Employer Information

| Employer Name: | | |
|---|---|---|
| Address: | | |
| City: | State: | Zip Code: |

| Contact Name: | FEIN: |
|---|---|
| Contact Phone Number: | Contact Email: |
| Date of Hire: | Termination Date: |

## Section 3: Employee Wages Paid for Employment in CT Only

Please enter gross wages paid by you, for work performed in CT in each of the calendar quarters for the past 2 years.

| Quarter | Year | Gross Wages Earned (CT Only) |
|---|---|---|
| | | $ |
| | | $ |
| | | $ |
| | | $ |
| | | $ |
| | | $ |
| | | $ |
| | | $ |

**Please only enter wages that are related to employment in the State of Connecticut. In the next section, you will be able to certify why those wages are not reported to the CT Department of Labor (if applicable).**

# 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: