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

Connecticut Paid Leave
Connecticut Paid Family and Medical Leave for Family Military Leave (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 experiencing need to care for a military family member injured during active duty

You are caring for family member that is a Current Service Member during their serious health condition.

In order to support your Paid Leave request, you and your family member's healthcare provider must complete:

- **Certification for Serious Injury or Illness of a Current Service Member for Military Caregiver Leave** form must be completed by; OR
- You must provide a copy of an *ITA (Invitational Travel Authorization)* or *ITO (Invitational Travel Order)*.

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. ☐ A certificate of Citizenship, Form N-560, or Form N-561, issued by DHS ☐ A certificate of Naturalization (Form N-550 or Form N-570)	☐ An SSN Card ☐ A W-2 Form ☐ An SSA-1099 Form ☐ A Non-SSA-1099 Form ☐ A pay stub with your full name and SSN on it ☐ 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
Certification for Serious Injury or Illness of a Current Service Member for Military Caregiver Leave

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

Applicant Name: *first* *middle* *last*	Case Number (if known):
Last 4 Digits of SSN:	Date of Birth:
Address:	
City:	State: Zip Code:
Cell Number:	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.

Who is the Paid Leave for?

To care for a Service Member during their serious health condition (select family member needing care):
☐ Domestic Partner ☐ Parent, or Domestic Partner's Parent ☐ Child ☐ Next of Kin

Family Service Member's Information

First Name:	Middle Name:	Last Name:	Date of Birth:
Address:	City:	State:	Zip Code:

Family Service Member's Health Care Provider Information

Health Care Provider's Name:		
Health Care Provider's Business Address:		
City:	State:	Zip Code:

Type of Health Care Provider you are:
- ☐ DOD Health Care Provider
- ☐ VA Health Care Provider
- ☐ DOD TRICARE network authorized Health Care Provider
- ☐ DOD non-network TRICARE authorized private Health Care Provider
- ☐ Health Care Provider as defined in 29.C.F.R. Section 825.125

Certificate license number and state:

Telephone:	Fax:	Email:

Connecticut Paid Leave
Certification for Serious Injury or Illness of a Current Service Member for Military Caregiver Leave

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

Medical Information (To be completed by the Family Service Member's Health Care Provider)

Please provide your contact information, complete all relevant parts of this Section, and sign the form. Your patient has requested leave under Connecticut Paid Leave (CT PL).

Limit your response to the medical condition(s) for which the employee is seeking CT Paid Leave. Your answers should be your best estimate based upon your medical knowledge, experience, and examination of the patient. After completing Part A, complete Part B to provide information about the amount of leave needed. Note: For CT PL purposes, "incapacity" means the inability to work, attend school, or perform regular daily activities due to the condition, treatment of the condition, or recovery from the condition. Do not provide 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).

1. State the approximate date the condition started or will start:_____ (mm/dd/yyyy)

2. Briefly describe the care you will provide to the Service Member:
   - ☐ Assistance with basic medical, hygienic, nutritional or safety needs
   - ☐ Psychological Comfort
   - ☐ Transportation
   - ☐ Physical Care
   - ☐ Other

3. Provide your best estimate of how long the condition lasted or will last:_____

4. If a reduced schedule is necessary to provide the care described, give your best estimate of the reduced work schedule they are able to work.
   From _____ (mm/dd/yyyy) to _____ (mm/dd/yyyy)
   They are able to work:_____ hours per day or_____ days per week.

5. Check the box(es) for the questions below, **as applicable**.
   The Service Member's injury or illness:
   - ☐ Was incurred in the line of duty on active duty.
   - ☐ Existed before the beginning of the Service Member's active duty and was aggravated by service in the line of duty or active duty.
   - ☐ None of the above.

   For all box(es) checked, the amount of leave needed must be provided in Question 8.

6. Is the Service Member undergoing medical treatment, recuperation, or therapy for this condition?
   ☐ Yes ☐ No If yes, briefly describe the medical treatment, recuperation, or therapy?

   _____
   _____
   _____
   _____
   _____

Connecticut Paid Leave
Certification for Serious Injury or Illness of a Current Service Member for Military Caregiver Leave

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

Medical Information (continued)

7. The current Service Member's medical condition is classified as (Select as appropriate):
   - ☐ **(VSI) Very Seriously Ill/Injured:** Illness/Injury is of such a severity that life is imminently endangered. Family members are requested at bedside immediately. Please note this is an internal DOD casualty assistance designation used by DOD healthcare providers.
   - ☐ **(SI) Seriously Ill/Injured:** Illness/injury is of such severity that there is cause for immediate concern, but there is no imminent danger to life. Family members are requested at bedside. Please note this is an internal DOD casualty assistance designation used by DOD healthcare providers.
   - ☐ **OTHER:** Ill/Injured: A serious injury or illness that may render the Service Member medically unfit to perform the duties of the member's office, grade, rank, or rating.
   - ☐ **NONE OF THE ABOVE:** Note to Employee: If this box is checked, you may still be eligible to take leave to care for a covered family member with a "serious health condition" under 29 C.F.R. § 825.113 of the FMLA. If such leave is requested, you may be required to complete DOL FORM WH-380-F or an employer-provided form seeking the same information.

8. **AMOUNT OF LEAVE NEEDED** - Complete all that apply. Some questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can; terms such as "lifetime," "unknown," or "indeterminate" may not be sufficient to determine CTPL coverage.
   - ☐ Due to the condition, the Service Member will need care for a **continuous period of time**, including any time for treatment and recovery.
     Provide your best estimate of the beginning date _____ *(mm/dd/yyyy)* and end date _____ *(mm/dd/yyyy)* for this period of time.
   - ☐ Due to the condition, it is medically necessary for the Service Member to **attend planned medical treatment appointments** (scheduled medical visits).
     Provide your best estimate of the duration of the treatment(s), including any period(s) of recovery _____ *(e.g. 3 days/week)*
   - ☐ Due to the condition, it is medically necessary for the Service Member to receive care on an **intermittent basis (periodically)**, such as the care needed because of episodic flare-ups of the condition or assisting with the Service Member's recovery.
     Provide your best estimate of how often (frequency) and how long (the duration) the intermittent episodes will likely last:
     Over the next 6 months, episodes of incapacity are estimated to occur _____ times per ☐ day / ☐ week / ☐ month and are likely to last approximately _____ ☐ hours / ☐ days per episode.

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 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).

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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:**

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: