



Connecticut Paid Leave Connecticut Paid Family and Medical Leave for Leave for Qualifying Exigency (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 a need to take time to address Qualifying Exigencies associated with a call to active duty

You are addressing specific exigent circumstances associated with the deployment of a parent, spouse, or child to overseas military duty.

You must complete:

- **Certification for Military Leave for Qualifying Exigency** form

You must provide:

- A copy of orders or letter of impending activation from the family members officer; **OR**
- copy of documentation validating the specific activity for which you are taking leave.

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

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.

CT PFL Application Document Checklist – continued from prior 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
<input type="checkbox"/> A certified copy of your birth certificate filed with a State Office of Vital Statistics or equivalent agency in your state of birth. <input type="checkbox"/> A certificate of Citizenship, Form N-560, or Form N-561, issued by DHS <input type="checkbox"/> A certificate of Naturalization (Form N-550 or Form N-570)	<input type="checkbox"/> An SSN Card <input type="checkbox"/> A W-2 Form <input type="checkbox"/> An SSA-1099 Form <input type="checkbox"/> A Non-SSA-1099 Form <input type="checkbox"/> A pay stub with your full name and SSN on it <input type="checkbox"/> An authorization letter from the IRS displaying your 9-digit individual tax identification number

Where do I send my application?

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

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

**Connecticut Paid Leave
Certification for Military Leave for Qualifying Exigency**

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: _____			Case Number (if known):
<i>first</i>	<i>middle</i>	<i>last</i>	
Last 4 Digits of SSN:	Date of Birth:		
Address: Street		City	State Zip Code
Cell Number:		Email:	
I consent to receiving <input type="checkbox"/> cell phone <input type="checkbox"/> email communications from Equitable related to my claim(s) at the email address and/or cell phone number provided above.			
Select Your Relationship to Service Member			
"Spouse" means a husband or wife as defined or recognized in the state where the individual was married, including same-sex marriage or domestic partnership. The terms "child" and "parent" include in loco parentis relationships in which a person assumes the obligations of a parent to a child. <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Child			
Service Member's Information			
First Name:	Middle Name:	Last Name:	
Date of Birth:			
Address:		City:	State: Zip Code:
Covered Active Duty Status			
Provide the dates of the Service Member's covered active duty service: _____			
<input type="checkbox"/> A copy of the Service Member's covered active duty orders.			
<input type="checkbox"/> Other documentation from the military indicating that the Service Member is on covered active duty or has been notified of an impending call to covered active duty, such as official military correspondence from the Service Member's chain of command.			
<i>Continued on next page.</i>			

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Connecticut Paid Leave

Certification for Military Leave for Qualifying Exigency (continued)

Qualifying Exigency Facts

Select the appropriate **Qualifying Exigency Category** and, if indicated, provide additional information related to the event:

- Short notice deployment (i.e., deployment within seven or fewer days of notice)
- Military events and related activities: (e.g., official ceremonies or events, or family support and assistance programs)

- Non-routine Childcare related activities for the child of the Service Member: (e.g., arranging for alternative childcare):

- Non-routine Care for the Service Member's parent: (e.g., admitting or transferring the parent to a new care facility):

- Financial and legal arrangements related to the deployment (e.g., obtaining military identification cards).
- Counselling related to the deployment (i.e., counselling provided by someone other than a health care provider).
- Service Member's short-term, temporary Rest and Recuperation leave (R&R): leave for this reason is limited to 15 calendar days for each instance of R&R
- Post deployment activities (e.g., arrival ceremonies, or reintegration briefings and events):

- Any other event that the employee and employer agree is a qualifying exigency:

Available written documentation supporting this request for leave is: attached not attached not available.

Amount of Leave Needed

Provide information concerning the amount of leave that is/was needed. Several questions in this section seek a response as to the frequency or duration of the qualifying exigency leave needed. Be as specific as you can; terms such as "unknown" or "indeterminate" may not be sufficient to determine paid leave coverage.

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

2. Provide your best estimate of how long the exigency lasted or will last:
From _____ (mm/dd/yyyy) to _____ (mm/dd/yyyy)

3. Due to a qualifying exigency, I need to work a **reduced schedule**. Provide your **best estimate** of the reduced schedule you are able to work:
From _____ (mm/dd/yyyy) to _____ (mm/dd/yyyy), I am able to work _____ (e.g. 5 hours/day, up to 25 hours a week).

4. Due to a qualifying exigency, I will need to be absent from work for a **continuous period of time**. Provide your **best estimate** of the beginning and ending for the dates for the period of absence:
From _____ (mm/dd/yyyy) to _____ (mm/dd/yyyy)

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**Connecticut Paid Leave
Certification for Military Leave for Qualifying Exigency**

Amount of Leave Needed (continued)		
<p>5. Due to the qualifying exigency, I will need to be absent from work on an intermittent basis (periodically). Provide your best estimate of how often (frequency) and how long (duration) of each appointment, meeting or leave event, including any travel time. Over the next 6 months, absences on an intermittent basis are estimated to occur: _____ times per <input type="checkbox"/> day / <input type="checkbox"/> week / <input type="checkbox"/> month and are likely to last approximately _____ <input type="checkbox"/> hours / <input type="checkbox"/> days per episode.</p>		
<p>6. My leave is due to a qualifying exigency that involves Rest and Recuperation leave (R&R) of the Service Member (leave for this reason is limited to 15 calendar days for each instance of R&R) List the dates of the Service Member's R&R leave: From _____ (mm/dd/yyyy) to _____ (mm/dd/yyyy)</p>		
Third Party Information		
<p>If applicable, please provide information below that may be used to verify meetings or appointments with a third party related to the qualifying exigency. Examples of meetings with third parties include arranging for childcare or parental care, to attend non-medical counselling, to attend meetings with school, childcare or parental care providers, to make financial or legal arrangements, to act as the Service Member's representative before a federal, state, or local agency for purposes of obtaining, arranging or appealing military service benefits, or to attend any event sponsored by the military or military service organizations. This information may be used to verify that the information contained on this form is accurate.</p>		
Individual (e.g., name and title) or Entity/Organization:		
Address:		
City:	State:	Zip Code:
Telephone:	Fax:	
Email:		
Describe purpose of meeting:		
<p>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.</p>		
Applicant Signature:		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: <hr/> <i>first</i> <i>middle</i> <i>last</i>		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: <input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent <input type="checkbox"/> 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):
<u>Please select the workdays that the employee typically works</u>		
<input type="checkbox"/> Sunday <input type="checkbox"/> Monday <input type="checkbox"/> Tuesday <input type="checkbox"/> Wednesday <input type="checkbox"/> Thursday <input type="checkbox"/> Friday <input type="checkbox"/> 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:		
<i>CT PFL Employment Verification Continued on next page.</i>		

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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):
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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:

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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

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 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:

Date: