EQUITABLE

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

Send completed forms to:
Equitable, EB Claims
8501 IBM Dr, Suite 150-C
Charlotte, NC 28262
Fax Number: (315) 477-2499
ebclaims@equitable.com

Massachusetts Paid Family and Medical Leave (PFML)

Application of Your Own Serious Health Condition

1 Employee Applying for Paid Medical Leave

Instructions - **Complete this Section with your own information.**

Your Name:

1. First: Middle: Last:

2. (If different) Your name as it appears on official documents like a driver's license or W2:
First: Middle: Last:

3. Phone #

4. Address:
Street _____ City _____ State _____ Zip _____

5. 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.

6. Gender: ☐ Male ☐ Female ☐ Other

7. Marital Status ☐ Married ☐ Single ☐ Widowed

8. Date of birth: _____
mm/dd/yyyy

9. Last 4 digits of your Social Security Number or Individual Taxpayer ID Number (ITIN):_____

10. Occupation:_____

• Employee

Write your name at the top of the remaining pages.
Afterwards, give this form to your health care provider to complete **Sections 2–4**.

MA PFML OSHC continued in 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.

MA PFML OSHC continued from prior page.

Massachusetts Paid Family and Medical Leave (PFML)

Certification of Your Own Serious Health Condition

• Employee

Employee applying for leave:

+ Health Care Provider

Health Care Provider Certification of a Serious Health Condition

2 Patient's Serious Health Condition

Instructions - This form should be filled out by the employee's healthcare provider. For the employee to qualify for paid leave, the patient must have a serious health condition. Answer all questions fully and completely.

11. Which of the following apply to the patient's serious health condition? Check all that apply; this includes mental health.

☐ Requires, or did require inpatient care.

☐ Has incapacitated or will incapacitate the patient for more than three consecutive full calendar days, **AND**
(pick one)
- ☐ Requires two or more medical visits within 30 days.

OR
- ☐ Requires one medical visit, plus a regimen of care.

☐ Is chronic, requires treatments at least twice a year,
and may require periodic absences.

☐ Is long-term and requires ongoing medical supervision, with or without active treatment.

☐ Requires multiple treatments and would lead to a period of incapacity without treatment.

☐ None of the above. (If **none** apply to the patient, the employee is **not** eligible for PFML)

12. Provide appropriate medical facts about the patient's serious health condition (e.g., symptoms, prescriptions, referrals for evaluation or treatment):

13. Is this serious health condition a job-related injury? ☐ Yes ☐ No

14. Is the patient's serious health condition related to pregnancy or recovery from childbirth? (Medical leave for pregnancy, prenatal care, or recovery from childbirth must meet the definition of a serious health condition.

Taking Medical Leave does not impact a patient's ability to take Family Leave to bond with their child, provided that the number of weeks taken for leave does not exceed the 26-week maximum in a benefit year. There is no form needed to take family leave to bond with a child- just proof of birth.)
☐ Yes ☐ No

If yes, how much time will the patient need?

- The patient will need approximately _____ weeks for pregnancy or prenatal care
- The patient will need approximately _____ weeks for recovery from childbirth or postnatal care.

15. When is the expected delivery date:_____
mm/dd/yyyy

MA PFML OSHC continued in next page.

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MA PFML OSHC continued from prior page.

Massachusetts Paid Family and Medical Leave (PFML)

Certification of Your Own Serious Health Condition

• Employee **Employee applying for leave:**

+ Health Care Provider

3 Estimate Leave Details

Instructions - The following questions are about the frequency or duration of a condition. Check all that apply to the patient's condition but you must provide your best estimate of the start and end dates and the duration based on your medical knowledge, experience, and examination of the patient.

16. ☐ **Continuous Leave:** Due to the condition, the patient is/will be incapacitated for a continuous period of time (completely unable to work for consecutive, uninterrupted days).

Provide your best estimate of the beginning date_____**(mm/dd/yyyy)** and end date _____ **(mm/dd/yyyy)** for the period of incapacity.

Do not use terms like "unknown" or "TBD" as it may result in delays and revisions to the form.

17. ☐ **Reduced Leave:** Due to the condition, it is medically necessary for the patient to work a reduced but consistent schedule.

Provide your best estimate of hours that the patient should take off per week during the reduced leave schedule. From _____ **(mm/dd/yyyy)** to_____ **(mm/dd/yyyy)** the patient is not able to work: **(e.g., 5 hours/day, up to 25 hours a week)**._____

Do not use terms like "unknown" or "TBD" as it may result in delays and revisions to the form.

18. ☐ **Intermittent Leave:** Due to the condition, it is medically necessary for the patient to be absent from work on an intermittent basis (multiple episodes of time off, which may be irregular or unexpected). Provide your best estimate of how often (frequency) and how long (duration) the episodes of incapacity will likely last.

From roughly:_____ **(mm/dd/yyyy)** to_____ **(mm/dd/yyyy)** (over the next 6 months), episodes of incapacity are estimated to occur_____times per **(☐ day ☐ week ☐ month)** and are likely to last approximately **(☐ hour ☐ days)** per episode.

Do not use terms like "unknown" or "TBD" as it may result in delays and revisions to the form.

MA PFML OSHC continued in next page.

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MA PFML OSHC continued from prior page.

Massachusetts Paid Family and Medical Leave (PFML)

Certification of Your Own Serious Health Condition

• Employee **Employee applying for leave:**

+ Health Care Provider

4 Provider Certification & Information.

Instructions - Sign and date to agree to this declaration. Provide the relevant licensing and contact information about your practice or business. Before returning the form, **review Pages 3-6**

I certify that the information provided in this form is true and correct, that I have examined the patient and answered the questions accurately and to the best of my ability, and that I am a health care provider authorized to certify their condition.

See **page 2** for the definition of a health care provider.

19. Signature _____ Date __ __ / __ __ / __ __ __ __ Mm/dd/yyyy

20. Printed name and title

Name: _____

Title: _____

21. Certificate/license to practice number:_____State/Country:_____

Note The form will not be accepted unless a license number is provided.

29. Area of practice or medical specialty:_____

30. Name of your practice or business:_____

31. Address:_____

31. Office phone #: __ __ __ - __ __ __ - __ __ __ __

32. Office fax #: __ __ __ - __ __ __ - __ __ __ __ (optional)

+ Health Care Provider **When you have completed and signed the certification, return it to the patient. The patient will submit this information for review by their employer and Equitable.**

Send completed form to:
Equitable, EB Claims
8501 IBM Dr, Suite 150-C
Charlotte, NC 28262
Fax Number: (315) 477-2499
ebclaims@equitable.com

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Massachusetts Paid Family and Medical Leave (PFML)
Employer Coverage Certification– to be completed by the Employer

Employer - send this completed form to Equitable:

Email: ebclaims@equitable.com **Mail:** Equitable, EB Claims
8501 IBM Dr, Suite 150-C
Charlotte, NC 28262
Fax Number: (315) 477-2499

Policy/Plan Holder Name: _____

Employee/Claimant Name: _____ Job title: _____

Social Security Number / TIN: _____ Date of Hire: _____
month/day/year

Address: _____
street city state zip

Phone number: _____ Email address: _____

Employment Status: Active_____ Terminated_____ If Terminated provide date of termination: _____

Does this employee meet the definition of an MA Employee/Worker? ☐ Yes ☐ No

Scheduled work days: _____ Number of hours worked per week: _____

Select the days of the week the employee usually works: ☐ Mon ☐ Tue ☐ Wed ☐ Thu ☐ Fri ☐ Sat ☐ Sun

What percentage, if any, do you contribute towards the cost of the Paid Medical Leave premium: _____%

Does the employee contribute toward the cost of the Paid Medical Leave premium? ☐ Yes ☐ No If **Yes**, ____%

Is it on a ☐ Pre-tax basis or ☐ Post-tax basis?

What percent of this employee's Medical Leave 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.

PFML leave start date: _____(mm/dd/yyyy) Last Date Worked: _____(mm/dd/yyyy)

Did employee work a full day? ☐ Yes ☐ No If **No**, how many hours did they work? _____

Is the Employee taking FMLA concurrently with PFL? ☐ Yes ☐ No If **Yes**, Leave Type: ☐ Continuous ☐ Intermittent

If applicable, please advise if your employee has been approved for MA Paid Family or Medical Leave benefits at all in the 12 Months preceding the start date of this leave? ☐ Yes ☐ No

If **Yes**, please indicate the type of leave taken and provide the inclusive dates as well as the total time approved:

Leave Type	**From** month/day/year	**Through** month/day/year	**Hours Approved**
PFL Bonding			
PFL Care of Family Member			
PFL Military Caregiver Leave			
PFL Military Exigency			
PML – Employee Own Illness			

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This page is not applicable to Military Exigency leave. Please continue to next page.

Is this employee covered under STD or LTD plans? If so, provide:

STD effective date _____ Prior coverage dates _____
month/day/year

LTD effective date _____ Prior coverage dates _____
month/day/year

What are the employee's physical job demands (pushing, pulling, standing, sitting, etc.):

_____

_____

_____

_____

Are you able to offer job accommodations to facilitate a return to work? ☐ Yes ☐ No

If **Yes**, describe: _____

_____

_____

_____

Is the Employee's condition work related? ☐ Yes ☐ No

If **Yes**, have they applied for WC benefits? ☐ Yes ☐ No

Continued on next page

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Earnings and Hours Worked.
Employer – please complete the grid below using the following guidance:

Total Gross Earnings Received and Total Number of Hours Worked, subject to MA PFML Law, by quarter during the base period.

Base Period means: *the last four completed calendar quarters immediately preceding the start date of the Paid Family and Medical Leave.*

If employee has been working for less than the qualifying base period, provide the number of weeks they worked and/or were paid for.

	CALENDAR QUARTER	TOTAL GROSS EARNINGS	TOTAL HOURS WORKED
1.			
2.			
3.			
4.			

Will the employer be making payments to the employee from a qualifying employer sponsored policy or program that are equal to or greater than the MA PFML benefit while on leave? ☐ Yes ☐ No

Will the employer be requesting reimbursement? ☐ Yes ☐ No

If **Yes**, please provide the dates From _____ Through _____
month/day/year month/day/year

Has the employee chosen to receive an accrued paid leave benefit such as PTO or accrued sick leave in lieu of MA Paid Family or Medical Leave benefit*(i.e., not a supplemental payment/top up)? ☐ Yes ☐ No

If **Yes**, please provide the dates From _____ Through _____
month/day/year month/day/year

**Note: Accrued Paid Leave time is not reimbursable. Employers are required to notify employees that Accrued Paid Leave time runs concurrently with MA Paid Family or Medical Leave and will be decremented from the employee's total Available allotment.*

Completed by: _____ Date: _____

Phone Number: _____ Email: _____

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Employer Short-Term Disability Addendum

If the employee is also covered by an Equitable Short-Term Disability policy, please complete the information below.

Please complete the following for STD benefits

Is this employee a Union member? ☐ Yes ☐ No

Is the employee Hourly _____ or Salaried ___?

What is this employee's weekly or hourly rate of pay? $_____

Is this employee receiving salary continuation or sick leave? Yes ____ No _____

If "**Yes**," please provide dates and payment amount. From _____ through_____
month/day/year month/day/year

What percentage, if any, do you contribute towards the cost of the STD premium?_____%

Is the Employer-paid premium added to the Employee's taxable wages? "Gross-Up" ☐ Yes ☐ No

Does the employee contribute towards the cost of the STD premium? ☐ Yes ☐ No

If **Yes**, at what percent? ____%

If **Yes**, is ☐ Pre-Tax basis or ☐ Post-Tax basis

What percent of this employee's STD benefit is taxable? _____ %

Note: Lack of response will result in the benefit being treated as 100% taxable.
Please refer to IRS Publication ***15-A Employer's Supplemental Tax Guide, Section 6, Sick Pay Reporting*** and/or ***IRS Revenue Ruling 2004-55*** for information on calculating the taxable percent

Completed by: _____ Date: _____

Phone Number: _____ Email: _____

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Clear Form

Federal Income Tax Withholding and Electronic Funds Transfer (EFT) Request Form

Paid Medical Leave – Federal Income Tax Withholding:

If you want us to withhold federal income tax, please indicate the dollar amount to be withheld per benefit check.

Whole dollars only (minimum is $20.00 per week): $_____.00

Please Note: If $20.00 Federal Income Tax withholding reduces your benefit to less than $10.00 per week, we can no longer withhold taxes.

EFT Instructions:

1. Read the Terms and Conditions listed below.
2. Enter your name, address, home telephone number and Employee ID.
3. Complete the bank 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.

Attn: EB Claims
8501 IBM Drive
Suite 150-C
Charlotte, NC 28262
Fax: (315) 477-2499
ebclaims@equitable.com

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 Equitable Financial Life Insurance Company, hereinafter called "The Insurance Company", and/or its Third Party Administrator, hereinafter called "TPA", and affiliated companies, 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(s):**

_____ _____

Signature(s): **Date(s):**

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TERMS AND CONDITIONS

Receiving benefits by direct deposit or electronic funds transfer is voluntary. If at any time during your leave you wish to revoke this EFT request, you can do so by contacting our office.

The Insurance Company and /or its TPA will not be responsible for any banking fees charged for direct deposit or electronic funds transfer; however, The Insurance Company and /or its TPA will not charge you any fees for depositing your benefits into this account.

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 herein.

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 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:

Signature:_____ Date:_____

Signature:_____ Date:_____