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)
Certification of Your Family Member's Serious Health Condition Instructions

You are required to notify your employer before submitting an application. Once you have notified your employer, **Equitable Financial Life Insurance Company of America (Equitable)** will review your application to determine your eligibility for benefits. Both the employee who is applying for leave and a health care provider must complete a portion of this form. **This form will be shared** with **Equitable**, your employer, employer affiliates, and state partners.

This form is required for...

✔ Leave to care for a family member with a serious health condition including a family member with a serious health condition related to military service.

This form is not required for Family Leave to...

✖ **Medical leave due to your own serious health** or conditions due to pregnancy or post-birth recovery that prevent you from working, as certified by a health care provider.

✖ **Bond with a child** within 12 months after birth, adoption, or foster care placement.

✖ **Manage affairs** for a family member who is an active service member.

How to use this form

• Employee

1. Complete **Section 1 and 2** and **Affidavit of Qualifying Family Relationship** to tell us about yourself and the family member you need to care for.
2. Write your name at the top of **Pages 5-7**.
3. Give **all pages** of the form to the health care provider who is treating your family member.
4. The health care provider should complete **Sections 3-5** and return the form to you. Benefits will be delayed or denied without certification from a health care provider.
5. Provide the **Employer Coverage Certification** to your employer to complete.
6. Send the **entire completed form** to

   Equitable, EB Claims
   8501 IBM Dr, Suite 150-C
   Charlotte, NC 28262
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   ebclaims@equitable.com

   Call our Contact Center at **(866)-274-9887** with any questions.

+ Health Care Provider (HCP)

1. Review **Page 2** for definitions of key terms.
2. Complete **Sections 3-5** to certify the patient's serious health condition.
3. Make sure the patient has provided authorization to share medical information with the employee.
4. Sign and return the **entire form** to the employee whose information is in **Section 1**.

Continued on next page

PFML-FORM-Cert-Family-SHC 5.0, March 2025
EBMAPFML-COFMINSTR (9/1/2025)

Massachusetts Paid Family and Medical Leave (PFML)
Certification of Your Family Member's Serious Health Condition Instructions

• Employee + Health Care Provider

Refer to this page as you fill out the form.

Definition of a serious health condition

A serious health condition could include an illness, injury, impairment or physical or mental condition that involves at least one of the following two conditions

1. At least one night of inpatient care in a hospital, hospice or residential medical facility
2. Continuing treatment by a health care provider

Inpatient care

An overnight stay in a hospital, hospice, or residential medical care facility, including any period of incapacity, or any subsequent treatment in connection with such inpatient care.

Continuing treatment

Treatment for a condition that fits any of the following descriptions:

A. Any incapacity to work for more than three consecutive full calendar days that also requires medical visits. Your patient's first visit must be within seven days of the start of incapacity. Telehealth appointments are also included. These medical visits must meet one of the following two patterns:
- Two or more visits within 30 days of a patient's incapacity to work (unless it is impossible to book two appointments in this time frame).
- One such visit—excluding a routine physical, eye or dental exam—plus a regimen of care or medication under the provider's supervision or prescription, e.g., outpatient surgery or strep throat.

B. Any incapacity due to pregnancy or prenatal care.

C. Any incapacity due to a chronic condition, which is a condition that:
- Requires periodic medical visits,
- Continues over an extended period of time, and
- May cause episodic periods of incapacity that require leave, e.g., asthma or migraine headaches.

D. Any incapacity due to a permanent or long-term condition that may not respond to treatment, e.g., Alzheimer's disease or terminal stages of cancer.

E. Any absence to receive multiple treatments, plus any recovery time, for either of the following:
- Restorative surgery after an accident or injury, e.g., joint replacements or reconstruction.
- A condition that would lead to more than three consecutive days of incapacity if the patient did not receive treatment, e.g., chemotherapy treatments.

Incapacity

An inability to perform the functions of one's job owing to the serious health condition. For unemployed applicants, it means an inability to perform the functions of their most recent position or other suitable employment.

Definition of a health care provider

Health Care Provider:

An individual licensed by the state, commonwealth, or territory in which the individual practices medicine, surgery, dentistry, chiropractic, podiatry, midwifery or osteopathy, and including the following:

A. Podiatrists, dentists, clinical psychologists, optometrists, and chiropractors (limited to treatment consisting of manual manipulation of the spine to correct a subluxation as demonstrated by X-ray to exist) authorized to practice in a state and within the scope of their practice as defined under the law of that state, commonwealth, or territory;

B. Nurse practitioners, nurse-midwives, clinical social workers and physician assistants who are authorized to practice under State law and who are within the scope of their practice as defined under the law of that state, commonwealth or territory.

C. Christian Science Practitioners listed with the First Church of Christ, Scientist in Boston, Massachusetts.

D. A health care provider listed above who practices in a country other than the United States, who is authorized to practice in accordance with the law of that country, and who is within the scope of practice as defined under such law.

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Massachusetts Paid Family and Medical Leave (PFML)

Certification of Your Family Member's Serious Health Condition

1 Employee Applying for Family Caring Leave

Instructions - Complete **Section 1** 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. Why are you applying for leave?
☐ To care for a family member with a serious health condition
☐ To care for a family member with a serious health condition related to military service

If you are applying for your own serious health condition, this is **not** the correct form. You need the **Certification of Your Serious Health Condition** form

11. Which kind of leave is it? ☐ Continuous ☐ Intermittent
Date being requested: from _____ to _____
mm/dd/yyyy mm/dd/yyyy

12. Occupation:_____

MA PFML COFM continued in next page.

MA PFML COFM continued from prior page.

2 Family member Information

Instructions - Complete Section 2 with your family member's information. Equitable needs to know your relationship with the patient to certify leave eligibility.

13. The family member who is experiencing a serious health condition is my:

- ☐ Child
- ☐ Parent of my spouse or domestic partner
- ☐ Grandparent
- ☐ Spouse or domestic partner
- ☐ Sibling
- ☐ Parent, or guardian who legally acted as my parent when I was a child
- ☐ Grandchild

For more detailed definitions of what family members fall into each of these categories see the Family Caring Leave Relationships listed in the Affidavit of Qualifying Family Relationship form

14 Family member's name:

First: Middle: Last:

15. Family member's name as it appears on official documents such as a driver's license or insurance documents (if different):

First: Middle: Last:

16 Family member's address:

Street:

Address Line 2:

City:

State: Zip code: County:

17. Family member's date of birth:

mm/dd/yyyy

18. Authorization:

I authorize Equitable Financial Life Insurance Company of America to use the information on this form to determine my eligibility for Paid Family and Medical Leave. I attest that I am applying for paid leave to care for a family member with a serious health condition, and I agree that Equitable can share this information with my employer, and employer affiliates, for the purpose of supporting my application for leave.

I certify that I have the authorization of the above-named family member to provide the information contained within this certification to Equitable for purposes of determining my eligibility for paid family leave.

• Employee Signature

mm/dd/yyyy

• Employee

Write your name at the top of the remaining pages.
Afterwards, give this form to your family member's health care provider to complete **Sections 3–5**.

MA PFML COFM continued in next page.

MA PFML COFM continued from prior page.

Massachusetts Paid Family and Medical Leave (PFML)

Certification of Your Family Member's Serious Health Condition

• Employee

Employee applying for leave:

+ Health Care Provider

3 Family Member's Serious Health Condition

Health Care Provider Certification of a Serious Health Condition

Instructions - This form should be filled out by **the healthcare provider of the patient**. The patient is the family member of the employee. The patient must have a serious health condition for the employee to qualify for paid leave to care for them. Answer all questions fully and completely.

19. 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)

20. Is this health condition related to the patient's military service? ☐ Yes ☐ No

21. Describe the relevant medical facts and appropriate information related to the condition for which the patient needs care. (Medical facts may include symptoms, prescriptions, or referrals for evaluation or treatment.)

22. Will the employee be required to take time off work to care for the patient? ☐ Yes ☐ No

23. Describe the kinds of care related to the patient's condition that the employee will provide (Examples of care may include providing medical, hygienic, nutritional, or safety needs that the patient is unable to perform themselves, e.g. transportation to the doctor.)

MA PFML COFM continued in next page.

MA PFML COFM continued from prior page.

Massachusetts Paid Family and Medical Leave (PFML)

Certification of Your Family Member's Serious Health Condition

• Employee **Employee applying for leave:**

+ Health Care Provider

4 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.

24. ☐ **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.

25. ☐ **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.

26. ☐ **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 COFM continued in next page.

MA PFML COFM continued from prior page.

Massachusetts Paid Family and Medical Leave (PFML)

Certification of Your Family Member's Serious Health Condition

• Employee **Employee applying for leave:** _____

+ Health Care Provider

5 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 to the employee, review to be sure you have signed it.

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.

27. Signature _____ Date _____ mm/dd/yyyy

28. Printed name and title

Name: _____

Title: _____

29. Certificate/license to practice number: _____ State/Country: _____

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

30. Area of practice or medical specialty: _____

31. Name of your practice or business: _____

32. Address: _____

33. Office phone #: _____

34. Office fax #: _____ (optional)

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

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Massachusetts Paid Family and Medical Leave (PFML)
Affidavit of Qualifying Family Relationship

You have received this Affidavit of Qualifying Family Relationship because you are applying to Equitable Financial Life Insurance Company of America (Equitable), your employer's private plan carrier, for family leave benefits either (1) to care for a family member with a serious health condition or (2) to manage a qualifying exigency arising from your family member's call to active duty.

Additional information and documentation of your relationship to the individual whose situation necessitates your leave is required. Family Caring Leave Relationships include:

- Your spouse or domestic partner
- Your children, stepchildren or domestic partner's children
- Your parents, stepparents or parent's domestic partner
- Your spouse or domestic partner's parents
- Your grandchildren, step-grandchildren or domestic partner's grandchildren
- Your grandparents, step-grandparents, or grandparent's domestic partner
- Your siblings or step-siblings

In addition, you can care for family members who are related through in loco parentis, custodial/non-custodial care, and/or as your legal ward.

When caring for a family member with a serious health condition, activities can include but are not limited to:

- Helping the family member with daily tasks they can't do themselves, such as helping them get dressed or preparing meals.
- Providing transportation to the doctor for appointments and treatment.
- Helping make arrangements for changes in care, such as a transfer to a nursing home.

Send this form and any relevant documentation, if available. The completed form and documentation must be emailed, mailed or faxed to Equitable at:

Email: ebclaims@equitable.com

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

Fax Number: (315) 477-2499

If you cannot email, fax or mail the form, please call our Contact Center at 866-274-9887.

Affidavit of qualifying family relationship – continued in next page

Massachusetts Paid Family and Medical Leave (PFML)
Affidavit of Qualifying Family Relationship (continued)

Claimant's Name: _____
First *middle* *last*

Claimant's NTN (if known): _____

Family Member's Name: _____
First *middle* *last*

Relationship to Claimant ("This person is my…"): _____
see list on prior page

Family Member's Date of Birth: _____
month/day/year

Please **select all** that apply and **sign below**.

- ☐ In order to verify that our relationship entitles me to family leave, I have attached a copy of the following documentation as proof of the relationship between the individual named on this form and me:
  - ☐ Birth Certificate
  - ☐ Marriage Certificate
  - ☐ Court document: _____
  - ☐ Other: _____

- ☐ I am unable to provide relevant supporting documentation.

I certify under penalty of perjury that the information contained in this form is true and correct and that the individual named on this form, whose situation necessitates my leave, is a covered family member under the PFML law.

Claimant Signature: _____ **Date:** _____

Please complete this form and attach any relevant documentation, if available. The completed form and documentation must be emailed, mailed or faxed to Equitable at:

Email: ebclaims@equitable.com

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

Fax Number: (315) 477-2499

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EQUITABLE

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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 a MA Employee/Worker? ☐ Yes ☐ No

PFML leave start date: _____ Last Date Worked: _____
month/day/year month/day/year

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			
PFL Care of Service Member			
PFL Military Exigency			
PML – Employee Own Illness			

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

Taxable Percent of MA PML Benefit: _____

Continued on next page

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

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.			

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.*

Please complete the following for STD and LTD benefits

Is this employee a Union member? ☐ Yes ☐ No

Is the employee Hourly ____ or Salaried ____ ?

Taxable Percent of STD Benefit: _____ Taxable Percent of LTD Benefit: _____

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

Completed by: _____ Date: _____

Phone Number: _____ Email: _____

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: