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 for Military Exigency Instructions

You are required to notify your employer before submitting this 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...

✔ **Military exigency leave**
Leave to manage affairs for a family member who is an active service member.

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.

✖ **Medical leave care for a family member with a serious health condition** including a family member with a serious health condition related to military service.

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

PFML Description of a Qualifying Exigency

Eligible employees may take Paid Family and Medical Leave (PFML) while the employee's spouse, child, or parent is on active duty or call to active duty status for one or more of the following qualifying exigencies.
A need arising out of a covered individual's family member's active duty or notice of an impending call or order to active duty in the Armed Forces including, but not limited to:

Short-Notice Deployment	Military Events and Related Activities	Childcare and School Activities
Arrangements for Family Care	Financial and Legal Arrangements	Counselling
Rest and Recuperation	Family Member Injured in Combat	Post-Deployment Activities

Additional qualifying events as defined in the federal Family and Medical Leave Act

How to use this form

• Employee

1. Complete **Section 1** and **Affidavit of Qualifying Family Relationship** to tell us about yourself and the family member whose affairs you need to manage.
2. Attach any documentation requested.
3. Provide the **Employer Coverage Certification** to your employer to complete.
4. Send all **completed forms** and **documentation** to:

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

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

PFML-FORM-Cert-Family-SHC 5.0, March 2025
EBMAPFML-MILEXIGINSTR (09/01/2025)

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Massachusetts Paid Family and Medical Leave (PFML)
Certification for Military Exigency

1 Employee Applying for Military Exigency Leave

Instructions – Complete form, attach documentation requested in #10 and #13, and submit to Equitable.

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. Relationship of covered military member to you: _____

7. Dates of covered military member's active duty service _____

8. Name of covered military member on active duty or call to active duty status:
First: Middle: Last:

9. Address of covered military member on active duty or call to active duty status:

Street _____ City _____ State _____ Zip _____

10. Please check one of the following:
☐ A copy of the covered military member's active duty orders is attached.
☐ Other documentation from the military certifying that the covered military member is on active duty (or has been notified of an impending call to active duty) in support of a contingency operation is attached.
☐ I have previously provided my employer with sufficient documentation confirming the covered military member's active duty or call to active duty status in support of a contingency operation.

Continued on next page.

Certification for Military Exigency - continued

11. Description of qualifying exigency: Please check the applicable category below:

- ☐ Short-Notice Deployment
- ☐ Military Events and Related Activities
- ☐ Childcare and School Activities
- ☐ Arrangements for Family Care
- ☐ Financial and Legal Arrangements
- ☐ Counselling
- ☐ Rest and Recuperation
- ☐ Post-Deployment Activities
- ☐ Family Member Injured in Combat
- ☐ Additional qualifying events as defined in the federal Family and Medical Leave Act

12. Describe the reason you are requesting leave due to a qualifying exigency (including the specific reason you are requesting leave):

_____

13. Please attach any available written documentation which supports the need for leave; such documentation may include a copy of a meeting announcement for informational briefings sponsored by the military, a document confirming an appointment with a counsellor or school official, or a copy of a bill for services for the handling of legal or financial affairs.
Available written documentation is attached: ☐ Yes ☐ none available

14. Approximate date exigency began or will begin: _____

How long will the exigency probably last? _____

Will you need to be absent from work for a single continuous period of time due to the qualifying exigency?

☐ Yes ☐ No If "**Yes**," estimate the beginning and ending dates for your absence:

Begin date _____ End date _____

15. Will you need to be absent from work periodically to address this qualifying exigency? ☐ Yes ☐ No

If "**Yes**," estimate the frequency and duration for each period of absence due to the qualifying exigency (e.g. 3 times per month lasting 4 hours):

Frequency:_____ times per _____ week(s) _____ month(s)

Duration: _____ hour(s) or _____ day(s) per event

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 manage affairs for a family member who is an active service member, 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 _____ Date _____

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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:

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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: