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

Oregon Paid Leave Benefits
Benefits Fact Sheet

Paid Leave Oregon is a program that allows employees in Oregon to take paid time off for some of life's most important moments that impact our families, health, and safety.

Family leave - to care for a family member with a serious illness or injury; or to bond with a new child after their birth, adoption, or placement in your home through foster care.

Medical leave - during one's own serious health condition.

Safe leave - for survivors of sexual assault, domestic violence, harassment, bias crimes, or stalking.

Can I use Paid Leave benefits if my family is sick or injured?
Yes. Paid Leave provides coverage for you to care for a family member with a serious health condition.

Who is considered my family under Paid Leave?
- Your spouse or domestic partner
- Your child (biological, adopted, stepchild, or foster child), your spouse or domestic partner's child, or the child's spouse or domestic partner
- Your parent (biological, adoptive, stepparent, foster parent, or legal guardian), the parent of your spouse or domestic partner, or your parent's spouse or domestic partner
- Your sibling or stepsibling or their spouse or domestic partner
- Your grandparent or your grandparent's spouse or domestic partner
- Your grandchild or your grandchild's spouse or domestic partner
- Any person you are connected to like a family member

How much paid leave can I take?
You can take 12 weeks of paid leave in a 52-week period, starting from the Sunday before your leave begins. You may be able to take an additional two weeks if you are pregnant, have given birth in the past year, or have health needs because of childbirth.

Do I have to use Paid Leave benefits in one block of time? Can I take a day or a week, and work in between those days or weeks?
Yes, you can take intermittent leave, which means you take leave days or weeks of leave between the start and end date of your leave, but you also work at your job(s) in between your start and end dates. You can work on any days you are not taking leave. You must also take intermittent leave if you are taking leave for two or more life events at the same time. You must send a weekly claim for benefits if you take intermittent leave. You can also take consecutive leave, which means that you take leave from the start date to the end date of your leave, without working at your job(s) during that time. You might also say that you are on full-time leave.

How much money will I get?
For many employees, Paid Leave will replace 100% of their wages. Your benefit amount is based on your average wages from the previous year. The minimum and maximum weekly amounts are based on the state average minimum wage. Minimum and maximum amounts are determined each year in July. The Paid Leave **website** lists these amounts.

Benefits Fact Sheet – continued

What are the requirements to collect Paid Leave benefits?

Employees requesting benefits must have:

- → Experienced a qualifying event
- → Completed an application
- → Earned $1,000 in wages in their **base year or alternate base year**
- → Contributed to the Paid Leave Oregon Trust Fund through paycheck deductions

When should I tell my employer I plan to take paid leave?

If you know you will need to take paid leave, you must notify your employer at least **30 days before** you take leave. If you need to take leave unexpectedly, you must give verbal notice within **24 hours** of starting your leave and provide any required written notice within **three days** after the start of your leave. Notify **Equitable Financial Life Insurance Company of America**, your employer's private plan carrier, of your plans to take leave:

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

Which employees are covered by Paid Leave?

Paid Leave covers most employees who work in Oregon, including those who are salaried, hourly, full-time, part-time, and seasonal.

Which employees are not covered by Paid Leave?

People who are not covered by paid leave are:

- → Federal
- → employees
- → Employees that only work outside of Oregon
- → Railroad workers exempted under the federal Railroad Unemployment Insurance Act
- → Most judges
- → Members of the Legislative Assembly
- → Public officials
- → or independent contractors
- → Individuals participating in state or federal work training assistance programs
- → Undergraduate or graduate students in work study programs
- → Volunteers who don't receive compensation
- → Tribal government employees
- → People who are self-employed

If I'm not covered by Paid Leave, can I choose to participate?

Tribal governments may choose to participate in Paid Leave, and then Paid Leave will cover their employees. People who are self-employed or independent contractors may also choose to participate in Paid Leave.

How is Paid Leave Oregon different from Family Medical Leave Act (FMLA) and Oregon Family Leave Act (OFLA)?

Each program has many rules and can be complex. A chart showing details is on the Paid Leave Oregon **website**. Please work with your human resources representative to determine which program best fits your needs.

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

EQUITABLE

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

Paid Leave Oregon
Statement of Rights
What you need to know

Paid Leave Oregon serves most employees in Oregon by providing paid leave for the birth, foster care placement, or adoption of a child, a serious illness of yours or a loved one, or if you or your child experience sexual assault, domestic violence, harassment, bias crimes, or stalking.

What benefits does Paid Leave Oregon provide and who is eligible?

Employees in Oregon that have earned at least $1,000 in their base year may qualify for up to 12 weeks of paid family, medical or safe leave in a benefit year. While on leave, Paid Leave pays employees a percentage of their wages. Benefit amounts depend on what an employee earned in their base year. See the Paid Leave website for a definition of base year.

Who pays for Paid Leave Oregon?

Employees and employers contribute to Paid Leave Oregon through payroll taxes. Contributions are calculated as a percentage of wages and your employer will deduct your portion of the contribution rate from your paycheck. When do I need to tell my employer about taking leave? If your leave is foreseeable, you must give notice to your employer at least 30 days before starting paid family, medical or safe leave. If you don't give the required notice, Paid Leave Oregon may reduce your first weekly benefit by 25%.

When do I need to tell my employer about taking leave?

If your leave is foreseeable, you must give notice to your employer at least 30 days before starting paid family, medical or safe leave. If you don't give the required notice, Paid Leave Oregon may reduce your first weekly benefit by 25%.

How do I apply for Paid Leave?

You can apply by contacting Equitable at (866)274-9887 or by email at ebclaims@equitable.com. If Equitable denies your benefits, you can appeal the decision.

What are my rights?

If you are eligible for paid leave, your employer can't prevent you from taking it. Your job is protected while you take paid leave if you have worked for your employer for at least 90 consecutive days. You won't lose your pension rights while on leave and your employer must keep giving you the same health benefits as when you are working.

How is my information protected?

Any health information related to family, medical or safe leave that you choose to share with your employer is confidential and can only be released with your permission, unless the release is required by law.

What if I have questions about my rights?

It is unlawful for your employer to discriminate or retaliate against you because you asked about or claimed paid leave benefits. If your employer isn't following the law, you have the right to bring a civil suit in court or to file a complaint with the Oregon Bureau of Labor & Industries (BOLI). You can file a complaint with BOLI online, via phone or email: www.oregon.gov/boli, 971-245-3844, help@boli.oregon.gov

Web: www.equitable.com Call: (866)274-9887
Email: ebclaims@equitable.com

EQUITABLE

Equitable Financial Life Insurance Company of America

For Assistance Call (866) 274-9887

Oregon Paid Leave
Oregon Paid Leave (PL) Instructions for Application for Benefits

You can apply for Paid Leave Oregon benefits by completing this application and including the appropriate documentation for your type of leave. We recommend learning about all benefit eligibility requirements before completing your application. You can find this information by calling us at (866) 274-9887.

You can send your application 30 days before the start date of your leave, or up to 30 days after this date. If circumstances outside of your control prevent you from sending your application during this 60- day time frame, Equitable may accept your application up to one year after the start of your leave. If you experience circumstances outside of your control, you need to send documentation to us explaining the cause of the delay. We will review your documentation and make a decision.

VERIFICATION OF LEAVE

You must show verification for your specific life event by including the appropriate verification document. We use this documentation to decide if you qualify for benefits, meet the definition for the type of leave you request, and calculate the amount of leave as well as the time frame you can claim benefits. Should you have questions about acceptable verification documents please contact Us. Be sure to include a legible copy of an accepted verification document with this application.

INFORMATION ON OTHER BENEFITS

Unemployment Insurance and Workers' Compensation time loss benefits

In any week in which you receive Workers' Compensation time loss benefits or Unemployment Insurance benefits, you can't receive Paid Leave benefits for that week.

Time loss benefits are workers' compensation benefits that replace an employee's wages.

Need Help? Contact us at:
(866)274-9887
Send completed form to:
Equitable, EB Claims
8501 IBM Dr, Suite 150-C
Charlotte, NC 28262
Fax Number: (315) 477-2499
ebclaims@equitable.com

OREGON PAID LEAVE (PL) APPLICATION

EQUITABLE

IDENTIFICATION

Social Security Number (SSN): _____ or

Individual Taxpayer Identification Number (ITIN): _____

Legal first name: _____

Legal middle name *(if any)*: _____

Legal last name(s): _____

Date of birth *(MM/DD/YYYY)*: _____

Driver's license or state identification number *(if you have one)*: _____

Issuing State: _____

Name:

CONTACT INFORMATION

Email address: _____

Phone number #1
☐ Cell phone
☐ Home phone
☐ Business phone
Phone number: (_____) _____ - _____

Phone number #2 *(optional)*
☐ Cell phone
☐ Home phone
☐ Business phone
Phone number: (_____) _____ - _____

I consent to receiving communications from Equitable related to my claim(s) at the email address and/or cell phone number provided above.

Yes, I consent to receiving ☐ cell phone ☐ email communications from Equitable.

No, I do not consent to receiving ☐ cell phone ☐ email communications from Equitable.

PHYSICAL ADDRESS

Street line 1: _____

Street line 2: _____

Unit type: _____ Unit number: _____

City: _____ State: _____ Zip: _____ County: _____

Attention: _____ Country: _____

MAILING ADDRESS *(If different from physical address)*

Street line 1: _____

Street line 2: _____

Unit type: _____ Unit number: _____

City: _____ State: _____ Zip: _____ County: _____

Attention: _____ Country: _____

Name:

TYPE OF LEAVE & DATES

What type of leave are you requesting? *(Select "Yes" to only one)*

Bonding leave. Are you taking family leave to care for and bond with a child during the first year after the child's birth or during the first year after the placement of the child through foster care or adoption?
☐ Yes ☐ No

Family leave. Are you taking family leave to care for a family member with a serious health condition?
☐ Yes ☐ No

Medical leave. Are you taking medical leave for your own serious health condition? ☐ Yes ☐ No

Safe leave. Are you taking safe leave because you, your child, or dependent is a survivor of sexual assault, domestic violence, harassment, bias crimes, or stalking? ☐ Yes ☐ No

Pre-placement leave. Are you taking pre-placement leave for necessary activities before adopting a child or having a foster child join your home? (You must take leave on an intermittent schedule with this type of leave. You must file a weekly claim for each week of leave you take.) ☐ Yes ☐ No

What date do you plan to start your leave? ____ / _____ / _____ *(MM/DD/YYYY)*

What is the end date of your requested leave? _____ / _____ / _____ *(MM/DD/YYYY)*

ADDITIONAL TYPE OF LEAVE QUESTIONS

Answer questions that are related to the type of leave you selected in the section above. Not all types of leave have additional questions.

Family-Care leave
Which family member are you taking leave to care for? ☐ Child ☐ Grandchild ☐ Grandparent
☐ Parent ☐ Sibling ☐ Spouse or Domestic Partner ☐ Other
If "Other" – Please explain the relationship that is the same as a family member.

_____

_____

Contact information for the person you are caring for:

First name: _____

Last name: _____

Phone number: (_____) _____ - _____

Name:

Address for the person you are caring for:

Street line 1: _____

Street line 2: _____

Unit type: _____ Unit number: _____

City: _____ State: _____ Zip: _____ County: _____

Attention: _____ Country: _____

What is the type of care or support you are providing for your family member? Select the option that best applies to your situation.

☐ Emotional support or comfort
☐ Making arrangements for medical care or completing other administrative tasks
☐ Medical or physical assistance
☐ Transportation to medical care
☐ Other

If "Other," please explain: _____

Safe leave

Who needs to take safe leave? ☐ For myself ☐ For my child or dependent

Note: Your child must be under the age of 18, and if they are 18 or older, they need to be a dependent adult with a physical or mental disability that limits their ability to live independently.

Please select the purpose(s) of your safe leave. *(Select the option(s) that best applies to your situation.)*

☐ To seek legal or law enforcement help for the health and safety of yourself, your child, or dependent, including preparing for and participating in court hearings that are related to sexual assault, domestic violence, harassment, bias crimes, or stalking
☐ To seek medical treatment for yourself, your child, or dependent or to recover from injuries caused by sexual assault, domestic violence, harassment, bias crimes, or stalking
☐ To get counseling for yourself, your child, or dependent from a licensed mental health professional because you, your child, or dependent are a survivor of sexual assault, domestic violence, harassment, bias crimes, or stalking
☐ To get services for yourself, your child, or dependent from a victim services provider because you, your child, or dependent are a survivor of sexual assault, domestic violence, harassment, bias crimes, or stalking
☐ To relocate or take steps to secure an existing home to protect yourself or the health and safety of your child or dependent
☐ None apply

Name:

Employer #1

Employer business name: _____

Federal Employer Identification Number (FEIN): _____

Business Identification Number (BIN): _____

Employer address

Street line 1: _____

Street line 2: _____

Unit type: _____ Unit number: _____

City: _____ State: _____ Zip: _____ County: _____

Attention: _____ Country: _____

Employer contact name: _____

Employer contact phone number: (___) _____ - _____

Employer contact email address: _____

Work and leave information

Date of hire: _____ / _____ / _____ *(MM/DD/YYYY)*

Are you still working for this employer: ☐ Yes ☐ No

If "No," last day worked _____ / _____ / _____ *(MM/DD/YYYY)*

Occupation *(job title)*: _____

Frequency of pay:

☐ Hourly
☐ Daily
☐ Weekly
☐ Bi-Weekly *(every two weeks)*
☐ Semi-Monthly *(twice per month)*
☐ Monthly
☐ Annually

For the frequency of pay you selected, what is your amount of pay? _____

Have you taken or do you plan to take leave from this employer? ☐ Yes ☐ No

If you are taking leave from this employer, how many days do you usually work per week for this employer? Circle one: 1 2 3 4 5 6 7

If you are taking leave from this employer, did you notify this employer about your leave? ☐ Yes ☐ No

If "Yes," when did you notify this employer? ___ / _____ / _____ *(MM/DD/YYYY)*

ADDITIONAL PREGNANCY LEAVE

Are you currently pregnant or have you given birth in the last year, and are you asking for an additional two weeks of leave for health issues related to pregnancy, childbirth, or a related medical condition?

☐ Yes ☐ No

If you aren't currently pregnant, please provide the date that your pregnancy ended:

_____/_____/_____ (MM/DD/YYYY)

LEAVE SCHEDULE

What is your type of leave schedule? *(Select only one)*

☐ **Intermittent leave schedule.** You take leave between the start and end date of your leave, but also work some days or weeks during this time frame. You may also be taking leave for two or more types of leave at the same time or you are taking pre-placement leave.
Note: By selecting this option, you must send us a Weekly Claim Form each week you take leave. You must send the form to us within 30 days from the end of each week you take leave. If your leave recently started, include the Weekly Claim Form with your application. See the Weekly Claim Form instructions for additional information. Call us at 866-274-9887 to ask for the form.

☐ **Consecutive leave schedule.** You take leave for one qualifying event at a time, and you do not work for any of your employers (or self-employment) during your approved leave time frame. To calculate your benefits, provide the following information. For Paid Leave, a week runs from Sunday through Saturday.

How many days of Paid Leave will you take during the **first week** you start leave? Circle one: 1 2 3 4 5 6 7

How many days of Paid Leave will you take during the **last week** of your leave? Circle one: 1 2 3 4 5 6 7

Name:	SSN/ITIN:

OTHER BENEFITS

Have you received or do you expect to receive Workers' Compensation time loss benefits during your leave?

☐ Yes ☐ No

Have you received or do you expect to receive Unemployment Insurance benefits during your leave?

☐ Yes ☐ No

Name:	SSN/ITIN:

CERTIFICATION

☐ I certify that the information I have provided is true and correct to the best of my knowledge and belief. Any person who makes a misstatement, misrepresentation, omission, or concealment made in connection with an insurance claim with the intent to knowingly defraud may be guilty of insurance fraud. Equitable Financial Life Insurance Company of America ("Equitable") may deny my claim based on any misstatement, misrepresentation, omission, or concealments on my part if Equitable shows that the misinformation is material and that Equitable relied upon the misrepresentation or the misrepresentation was provided fraudulently.

In addition to those disclosures authorized by applicable law, I authorize Equitable to release relevant claim information to my employer(s), including but not limited to, information about my application for leave; the approval or denial of my claim; the dates, duration, and frequency of leave; and my weekly benefit amount. I also authorize the disclosure of the foregoing information to the administrator or other service providers of my employers' benefit plan(s) and/or programs for plan, benefit, or program related functions or data aggregation or analysis, and to any electronic claim systems or programs or third party vendors used for claims administration or processing or to any insurance broker to carry out functions related to my benefit plan or claim.

I authorize Equitable Financial Life Insurance Company of America to release relevant claim information to health care providers related to my paid leave claim.

I understand that I must notify Equitable Financial Life Insurance Company of America about any change to the information I provided in this application, including the dates and amount of leave, and changes to my employment.

_____ _____

Signature Date *(MM/DD/YYYY)*

Missing information or documents can cause a delay in processing your application for benefits.

Mail your completed application and all required documents to:

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

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

EQUITABLE

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

Paid Leave Oregon
Employer Statement

Instructions for Employer: Please complete the following information and return to **Equitable** within 10 calendar days of receipt from your employee.

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

Questions? Call Equitable at (866) 274-9887

Claimant's Name _____ SSN# _____
first middle last

Employer Name:

Employer Tax ID	SIC Code

Address

Street City State Zip Code

Contact Name	Title

Contact Phone	Email

Employee date of hire	Employee date of termination (if applicable)

Employee's job title	Date last worked

Has the employee returned to work? ☐ Yes ☐ No Return to Work Date: _____ ☐ Actual ☐ Estimated

Oregon Employer Statement - continued

1. **Employee Benefit Eligibility Verification.** I affirm the forementioned employee (1) works for a covered Oregon employer; and (2) has earned a minimum of $1,000 in the base period or alternate base period
   ☐ Employee ***HAS*** met the eligibility requirement ☐ Employee has ***NOT*** met the eligibility requirement

2. **LAST ACTUAL DAY WORKED** before this leave began (do not use payroll week ending dates)

   _____
   (Month/Day/Year)
   a. Reason for separation from work if other than disability _____
   b. Is lack of work: ☐ temporary? ☐ permanent?
   c. Has claimant returned to work? ☐ Yes ☐ No If "Yes", give date _____ (Month/Day/Year)
   d. If the work was intermittent, list dates: _____(Month/Day/Year)

3. Please select the workdays that the employee typically works
   ☐ Sunday ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday

4. **Prior Leaves** taken by employee in the preceding 52 weeks:
   ☐ Family (PFL) ☐ Medical (PML) ☐ Both PML and PFL ☐ None
   Enter the total PFL and PML time taken in the past 52 weeks:
   Family (PFL) = _____ Dates _____ THROUGH _____ (Month/Day/Year)
   Medical (PML) = _____ Dates_____ THROUGH _____ (Month/Day/Year)

5. **CONTINUED PAY** (do not enter wages earned prior to disability)
   a. Have you paid, or do you expect to pay the claimant for any period after the last day of work? ☐ Yes ☐ No
   b. If "yes" give dates: FROM _____ TO _____ (Month/Day/Year)
   c. Amount per week $_____, if amount varies attach list of dates and amounts,
   d. Check the box that best describes the monies paid in items a-c.
      1. ☐ Regular weekly wages/sick pay/PTO
      2. ☐ Regular vacation (if designated for a specific time period)
      3. ☐ Difference between regular weekly wage and disability benefits
      4. ☐ Other _____
   e. If continuing to advance employee 100% of their wages, are you requesting reimbursement of the OR PFML benefits payable to your employee? ☐ Yes ☐ No

6. Does the employee contribute to the cost of the OR PFML coverage? ☐ Yes ☐ No If No, skip to question # 7
   a. If Yes, is the employee contributing at the current maximum State allowable contribution? ☐ Yes ☐ No (If yes, skip to "c" below.)
   b. If No to "a" above, what monthly dollar amount does the employee contribute to the OR PFML premium? $_____/month
   c. Does this claimant contribute to their OR PFML premiums on a:
      ☐ Pre-tax basis (Benefit is fully taxable)
      ☐ Post-tax basis (Benefit is taxable in proportions to the employer's contribution)

IMPORTANT: This information is needed to accurately tax any benefits payable.

Oregon Employer Statement - continued

7. **HOW TO DETERMINE AVERAGE WEEKLY WAGE**

Benefits are calculated using an employee's Average Weekly Wage (AWW). AWW is calculated using total wages earned during the Base Year or Alternate Base Year, by the number of weeks in the respective Base Year.

Base Year: This term means the first of the five most recently completed calendar quarters immediately preceding the Benefit Year.

Alternate Base Year: This term means the last four completed calendar quarters preceding the Benefit Year.

Base Year: This term means the first four of the five most recently completed calendar quarters immediately preceding the Benefit Year.

Benefit Year: This term means 52 consecutive weeks beginning on the Sunday immediately preceding the date that family, medical or safe leave commences for the claimant, except that the benefit year shall be 53 weeks if a 52 week benefit year would result in an overlap of any quarter of the base year of a previously filed valid claim. A claimant may only have one valid benefit year at a time.

Base Year Example:

Quarter 1 = 04/01/2022 to 06/30/2022
Quarter 2 = 07/01/2022 to 09/30/2022
Quarter 3 = 10/01/2022 t0 12/31/2022
Quarter 4 = 01/01/2023 to 03/31/2023
Quarter 5 = 04/01/2023 to 06/30/2023

Average Weekly Wage (AWW) Calculation:
AWW: Total Earned Wages from Base Year / # of weeks in Base Year.

Base Year Wages	Quarter Ending Date	Quarterly Wages ($)
Quarter 1		
Quarter 2		
Quarter 3		
Quarter 4		
Quarter 5		

a. Total gross wages for the first 4 out of the last 5 COMPLETE quarters $_____

b. Total number of base weeks for the first 4 of the last 5 COMPLETE quarters _____

8. Is this employee subject to: Social Security taxes? ☐ Yes ☐ No Medicare taxes? ☐ Yes ☐ No

Employer Certification

Certification and Signature Any person who knowingly and with intent to defraud any insurance company files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading. Information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty. I am hereby making a request for paid family leave benefits under the Oregon Paid Family and Medical Leave Insurance statutes and regulations. My signature affirms that the information I am providing is true and accurate to the best of my knowledge and belief.

Signature	Date
Print or Type Name first middle last	Official Title

EQUITABLE

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

Paid Leave Oregon
Verification of Serious Health Condition Form Instructions

INSTRUCTIONS FOR CLAIMANT

Use this form if you are:

- Applying for medical leave for your own serious health condition **OR**
- Applying for family leave to care for a family member with a serious health condition.

The patient's health care provider must sign this form. Learn what qualifies as a serious health condition and see the list of authorized health care providers in the Instructions for Health Care Provider section below.

Instructions:

- **Part A:** Complete this section with your own information as the claimant. You must include your full name.
- **Part B:** Only complete Part B if you are applying for family leave to care for a family member with a serious health condition. Complete this section with your family member's information. You must include your family member's full name. Do not complete this section if you are applying for paid leave due to your own serious health condition.
- **Part C and D:** Provide the form and Instructions for Health Care Providers to the patient's authorized health care provider. Make sure that the authorized health care provider verifying the serious health condition completes and signs sections C and D.

  Important:
  - The form may not be dated and signed more than 60 days before your expected leave start date. We do not accept forms that were signed before this date.
  - The form may not be altered after it was filled out and signed (for example, no strikeouts or whiteouts). We cannot accept forms that have been altered in any way. If you or your health care provider need to fill out a new form, you can contact **Equitable** at ebclaims@equitable.com or call **Equitable** at 866-274-9887.

You must provide all required information. Missing information can cause a delay in processing your benefit claim or a denial of your claim.

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

Need help?
This information is vital. The Oregon Employment Department (OED) is an equal opportunity agency. OED provides free help so you can use our services. Some examples are sign language and spoken- language interpreters, written materials in other languages, large print, audio, and other formats. To get help, please call 866-274-9887. TTY users call 711. You can also send an email to ebclaims@equitable.com

Verification of Serious Health Condition Form Instructions - continued

INSTRUCTIONS FOR HEALTH CARE PROVIDERS

Claimants use this form to verify that:

- They qualify for medical leave for their own serious health condition **OR**
- They qualify for family leave to care for a family member with a serious health condition.

The patient's health care provider who is authorized to certify the claimant's or the family member's serious health condition must complete and sign this form.

To certify the serious health condition:

- Review the information below to make sure you meet the definition of an authorized health care provider and to make sure the patient's condition meets the definition of a serious health condition.
- **Only** complete Parts C and D of this form.
- **Part C:** Answer all questions about the patient's serious health condition and the need for leave.
  Important:
  - You must include a diagnosis or a description of symptoms or required treatment sufficient to verify the condition, the approximate date the condition started or created a need for leave, and an estimate of the length of leave your patient needs. If the claimant is applying for intermittent leave, also include an estimated frequency of the condition or treatment per week.
- **Part D:** Complete this section with your information. You must also sign and date this section. By signing this form, you confirm that you are a health care provider as defined in OAR 471-070-1000, and that the information on this form is true and correct.
  Important:
  - You may not sign this form more than 60 days before the claimant's expected leave start date. We cannot accept forms that were signed before this date.
  - You may **not** alter the form in any way after you fill it out and sign it (for example, no strikeouts or whiteouts). We cannot accept forms that have been altered in any way. If you need to fill out a new form, you can find it at ebclaims@equitable.com or by requesting one from Equitable.
- Return the completed and signed form to the claimant. They will send this form with their application for benefits to Equitable Financial Life Insurance Company of America.

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

Heath care provider definition:

OAR 471-070-1000 defines a "health care provider" as:

1. A person who is primarily responsible for providing health care to the claimant or the family member of the claimant before or during a period of Paid Leave, who is licensed or certified to practice in accordance with the laws of the state or country in which they practice, who is performing within the scope of the person's professional license or certificate, and who is a(n):
   - Chiropractic physician (only to the extent the chiropractic physician provides treatment consisting of manual manipulation of the spine to correct a subluxation demonstrated to exist by X-rays)
   - Dentist
   - Direct entry midwife

Verification of Serious Health Condition Form Instructions - continued

- Naturopathic physician
- Nurse practitioner
- Nurse practitioner specializing in nurse-midwifery
- Optometrist
- Physician
- Physician associate
- Psychologist
- Registered nurse
- Regulated social worker

2. A person who is primarily responsible for the treatment of the claimant or the family member of the claimant solely through spiritual means before or during a period of paid leave, including but not limited to a Christian Science practitioner.

Serious health condition definition:

OAR 471-070-1000 defines a "serious health condition" as:

An illness, injury, impairment, or physical or mental condition of a claimant or their family member that:

- Requires inpatient care in a medical care facility such as a hospital, hospice, or residential facility such as a nursing home
- In the medical judgement of the treating health care provider poses an imminent danger of death, or that is terminal in prognosis with a reasonable possibility of death in the near future
- Requires constant or continuing care, including home care administered by a health care professional
- Involves a period of incapacity. "Incapacity" is the inability to perform at least one essential job function, or to attend school or perform regular daily activities for more than three consecutive calendar days. A period of incapacity includes any subsequent required treatment or recovery period relating to the same condition. The incapacity must involve one of the following:
  - Two or more treatments by a health care provider
  - One treatment plus a regimen of continuing care
- Results in a period of incapacity or treatment for a chronic serious health condition that requires periodic visits for treatment by a health care provider, continues over an extended period of time, and may cause episodic rather than a continuing period of incapacity, such as asthma, diabetes, or epilepsy
- Involves permanent or long-term incapacity due to a condition for which treatment may not be effective, such as Alzheimer's Disease, a severe stroke, or terminal stages of a disease. The employee or family member must be under the continuing care of a health care provider, but need not be receiving active treatment
- Involves multiple treatments for restorative surgery or for a condition such as chemotherapy for cancer, physical therapy for arthritis, or dialysis for kidney disease that if not treated would likely result in incapacity of more than three calendar days
- Involves any period of disability due to pregnancy, childbirth, miscarriage or stillbirth, or period of absence for prenatal care
- Involves any period of absence from work for the donation of a body part, organ, or tissue, including preoperative or diagnostic services, surgery, post-operative treatment, and recovery.

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

EQUITABLE

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

Paid Leave Oregon
Verification of Serious Health Condition Form

PART A: CLAIMANT INFORMATION (To be completed by claimant. ***All fields are required unless otherwise noted.***)

Name: _____
first middle last

Social Security number (SSN) or Individual Taxpayer Identification Number (ITIN): _____ (optional)

Date of birth (MM/DD/YYYY):

Requested type of leave:
☐ Medical leave due to claimant's own serious health condition
☐ Family leave to care for family member with serious health condition

PART B: PATIENT INFORMATION *(If requesting family leave, to be completed by claimant)*

Name: _____
first middle last

Relationship to claimant:

PART C: HEALTH CARE PROVIDER CERTIFICATION *(To be completed by the patient's authorized health care provider.* ***All fields are required unless otherwise noted.)***

An authorized health care provider must complete and sign this section. Incomplete or altered forms may cause a delay or a denial of the claimant's benefits.

Provide relevant medical facts sufficient to verify the serious health condition. This must include a diagnosis or a description of symptoms or required treatment for the serious health condition. Your answers should be your best estimate based on your medical knowledge, experience, and examination of the patient.

_____

_____

_____

_____

_____

Primary ICD-10 Code (optional): _____

Continued on next page

Verification of Serious Health Condition Form - continued

PART C: HEALTH CARE PROVIDER CERTIFICATION *(To be completed by the patient's authorized health care provider.* ***All fields are required unless otherwise noted.)*** *(Continued)*

Which of the following apply to the patient's serious health condition? Check all that apply:

- ☐ **Inpatient care:** The patient has been admitted, or is expected to be admitted, for an overnight stay in a hospital, hospice, or residential medical care facility.
- ☐ **Danger of death or terminal prognosis:** The condition poses an imminent danger of death or is terminal in prognosis.
- ☐ **Continuing care:** The condition requires constant or continuing care *(for example, home care by a health care professional)*
- ☐ **Incapacity plus treatment:** *(for example, outpatient knee surgery, broken leg)* The condition involves a period of incapacity, meaning that the patient is unable or will be unable to perform at least one essential job function or regular daily activities for more than three consecutive calendar days AND *(pick one)*
  - ☐ Requires two or more treatments, OR
  - ☐ Requires one treatment and ongoing care
- ☐ **Chronic condition:** *(for example, asthma, diabetes, epilepsy)* The condition requires the patient to have repeated treatment visits over an extended time. The condition may cause episodes of incapacity, rather than continuous incapacity.
- ☐ **Permanent or long-term condition***: (for example, Alzheimer's, terminal stages of cancer)* Due to the condition, the patient's incapacity is permanent or long term and requires the continuing care of a health care provider even if they are not receiving active treatment.
- ☐ **Condition requiring multiple treatments:** *(for example, chemotherapy, restorative surgery)* Due to the condition, it is medically necessary for the patient to receive multiple treatments. If the patient did not receive treatments, it would likely result in incapacity for more than three calendar days.
- ☐ **Pregnancy and childbirth:** The patient is experiencing a period of disability due to pregnancy, childbirth, miscarriage, stillbirth, or they require a period of absence from work due to prenatal care.
- ☐ **Organ/body part/tissue donor:** The donation requires an absence from work, including for preoperative or diagnostic services, surgery or post-operative treatment and recovery.
- ☐ **None of the above:** The patient's condition does not fit any of the above serious health condition categories.
  Important: If you check this box, the patient's condition does not meet the criteria of a serious health condition and the claimant does not qualify for medical or family leave.

Provide the date the serious health condition started, the date it created a need for leave (if different) and an estimated end date. Please note that terms such as "unknown" or "indeterminate" are not sufficient to determine eligibility for Paid Leave Oregon benefits.

Condition start date *(MM/DD/YYYY):* _____

Date condition created need for leave (if different from condition start*) (MM/DD/YYYY):* _____

(Estimated) end date *(MM/DD/YYYY):* _____

Continued on next page

Verification of Serious Health Condition Form - continued

PART C: HEALTH CARE PROVIDER CERTIFICATION *(To be completed by the patient's authorized health care provider.* ***All fields are required unless otherwise noted.)*** *(Continued)*

If the condition is chronic or permanent, check the box below and provide a start and expected end date for the current episode of the condition.

☐ Chronic or permanent condition current episode start date _____ (month/day/year)
current episode expected end date _____(month/day/year)

Does the condition or treatment impact the patient intermittently (not every day)?
☐ Yes ☐ No

If yes, what is the maximum expected frequency of the condition or treatment?
☐ One day per week
☐ Two days per week
☐ Three days per week
☐ Four days per week
☐ Five days per week
☐ Six days per week
☐ Seven days per week

Please provide information on the expected weekly frequency of the condition or treatment plan in as much detail as possible: _____

_____

_____

_____

If the serious health condition is due to pregnancy, please confirm that the patient is currently pregnant or was pregnant in the year prior to the leave start date: ☐ Yes ☐ No
Child's date of birth or expected delivery date *(MM/DD/YYYY)*: _____

PART D: HEALTH CARE PROVIDER INFORMATION AND SIGNATURE *(To be completed by the patient's authorized health care provider)*

☐ I have read the definitions of health care provider and serious health condition (OAR 471-070-1000). I declare that the information provided in this form is true and correct and that I am a health care provider as defined in OAR 471-070-1000.

Health care provider signature (handwritten or electronic):	Date:

Name: _____
first middle last

Certificate license number (optional):	Title or specialization:	U.S. state or country:

Type of practice or medical specialty:

Phone:	Email address *(optional)*

Business name:

Address_____
Street city state zip code

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 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: ☐ **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 **Equitable** 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: **Date:**

_____ _____
Signature: **Date:**

*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. Equitable Advisors is the brand name of Equitable Advisors, LLC (member FINRA, SIPC) (Equitable Financial Advisors in MI & TN). The obligations of Equitable Financial Life Insurance Company and Equitable Financial Life Insurance Company of America are backed solely by their claims-paying abilities.

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 of Other Person(s) on Account: **Date:**