



EQUITABLE

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.

Equitable is the brand name of the retirement and protection subsidiaries of Equitable Holdings, Inc., including Equitable Financial Life Insurance Company (NY, NY); Equitable Financial Life Insurance Company of America, an AZ stock company with an administrative office located in Charlotte, NC; and Equitable Distributors, LLC. The obligations of Equitable Financial Life Insurance Company and Equitable Financial Life Insurance Company of America are backed solely by their claims-paying abilities. Benefits

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.

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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:
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Email: ebclaims@equitable.com

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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:

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Charlotte, NC 28262

Fax Number: (315) 477-2499

ebclaims@equitable.com

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OREGON PAID LEAVE (PL) APPLICATION



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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: _____

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OREGON PAID LEAVE (PL) (continued)

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: _____

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OREGON PAID LEAVE (PL) (continued)

Name: _____

TYPE OF LEAVE & DATESWhat 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 leaveWhich 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: (____) ____ - ____

OREGON PAID LEAVE (PL) (continued)

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 leaveWho 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

OREGON PAID LEAVE (PL) (continued)

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

☐ Semi-Monthly (*twice per month*)

☐ Daily

☐ Monthly

☐ Weekly

☐ Annually

☐ Bi-Weekly (*every two weeks*)

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

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OREGON PAID LEAVE (PL) (continued)

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	

OREGON PAID LEAVE (PL) (continued)

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	

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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

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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.

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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 to 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	Official Title
first middle last	

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Paid Leave Oregon

Safe Leave Verification Form Instructions

Instructions for claimant

To qualify for safe leave, you must send verification certifying that you, your child, or dependent are a survivor of sexual assault, domestic violence, harassment, bias crimes, or stalking. You must provide one of the following documents:

- A copy of a police report
- A copy of a protective order or other evidence from a court, administrative agency, school's Title IX coordinator, or attorney
- A formal complaint to a school's Title IX coordinator
- Documentation from an attorney, law enforcement officer, health care provider, licensed mental health professional or counselor, member of the clergy, employee of the Department of Justice division providing victim and survivor services, or victim services provider
- This form

Call us if you have difficulty getting one of these documents or if you have concerns for your safety or the safety of your child or dependent while getting one of these documents.

If you have more questions about safe leave, contact **Equitable** at (866) 274-9887 or ebclaims@equitable.com.

To use this form, first fill in the **Claimant Information** section. Next, give this form to **one** of the following to fill out the verification section:

- Law enforcement officer
- School Title IX coordinator
- Attorney
- Health care provider
- Licensed mental health professional or counselor
- Member of the clergy
- Employee of the Department of Justice (DOJ) providing victim services
- Victim services provider

These are all people who can verify that you, your child, or dependent were or are currently undergoing treatment or counseling, getting services, or relocating because of sexual assault, domestic violence, harassment, bias crimes, or stalking.

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 is the brand name of the retirement and protection subsidiaries of Equitable Holdings, Inc., including Equitable Financial Life Insurance Company (NY, NY); Equitable Financial Life Insurance Company of America, an AZ stock company with an administrative office located in Charlotte, NC; and Equitable Distributors, LLC. The obligations of Equitable Financial Life Insurance Company and Equitable Financial Life Insurance Company of America are backed solely by their claims-paying abilities.

Safe Leave Verification Form Instructions - continued

Instructions for the person filling out the verification section

The claimant will use this Verification of Safe Leave Form to verify that they, their child, or dependent are a survivor of sexual assault, domestic violence, harassment, bias crimes, or stalking as part of their application for safe leave.

Please review the information below to make sure you can verify this information and that you understand when a claimant can qualify for safe leave (*see the list of qualifying life events below*).

Safe leave qualifying life events

A person is covered under safe leave if any of the following apply to them:

- They, their child, or dependent need legal assistance or help from the police to protect themselves or their child's health and safety. This includes preparing for and participating in court hearings that are related to being a survivor of sexual assault, domestic violence, harassment, bias crimes, or stalking.
- They, their child, or dependent needs medical treatment to recover from injuries caused by sexual assault, domestic violence, harassment, bias crimes, or stalking.
- They, their child, or dependent are getting counseling from a mental health professional because they, their child, or dependent are a survivor of sexual assault, domestic violence, harassment, bias crimes, or stalking.
- They, their child, or dependent are getting services from a victim services provider because they, their child, or dependent are a survivor of sexual assault, domestic violence, harassment, bias crimes, or stalking.
- They need to move or make their current home secure to protect themselves, their child, or dependent's health and safety.

If safe leave involves their child, the child must be under the age of 18. If they are 18 years or older, they need to be a dependent adult with a physical or mental disability that limits their ability to live independently.

If you have more questions about safe leave, contact **Equitable** at ebclaims@equitable.com.

Need help?

The Oregon Employment Department (OED) is an equal opportunity agency. OED provides free help so you can use their 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 833-854-0166 (toll-free). TTY users call 711. You can also send an email to paidleave@oregon.gov.

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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**Safe Leave Verification Form**

CLAIMANT INFORMATION <i>(To be completed by claimant)</i>	
Name: _____ first middle last	
Social Security number (SSN) or Individual Taxpayer Identification Number (ITIN): _____	
Date of birth (MM/DD/YYYY): _____	
I am taking leave: ☐ For myself ☐ For my child or dependent	
Verification Section <i>(To be filled out by one of the following)</i>	
LAW ENFORCEMENT OFFICER <i>(To be completed by a law enforcement officer)</i>	
Name: _____ first middle last	
Title: _____	Rank/division: _____
Badge number: _____	Department/agency: _____
Phone number: _____	Email address: _____
☐ This is a safe leave related situation ☐ This is not a safe leave related situation	
_____ Signature Date	

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Safe Leave Verification Form - continued

TITLE IX COORDINATOR *(To be completed by a Title IX coordinator)*

Name: _____
first middle last

Title:	Date of contact:
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School district/college/university:	Department/program:
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Phone number:	Email address:
---------------	----------------

- ☐ This is a safe leave related situation
☐ This is not a safe leave related situation

Signature Date

OTHER *(To be completed by an attorney, health care provider, licensed mental health professional or counselor, member of the clergy, Department of Justice employee providing victim services, or victim services provider that helped the claimant, their child, or dependent receive treatment, receive counseling services, or relocate as a result of being a survivor of sexual assault, domestic violence, harassment, bias crimes, or stalking.)*

Name: _____
first middle last

Title:	Date of contact:
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Profession:	License number <i>(if relevant)</i> :
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Employer name:

Phone number:	Email address:
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- ☐ This is a safe leave related situation
☐ This is not a safe leave related situation

Signature Date

Provide all required information. Missing information and documentation can cause a delay in processing your application for benefits.

Send completed form with your Paid Leave Application for Benefits to:

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

Fax Number: (315) 477-2499

Email: ebclaims@equitable.com

Equitable is the brand name of the retirement and protection subsidiaries of Equitable Holdings, Inc., including Equitable Financial Life Insurance Company (NY, NY); Equitable Financial Life Insurance Company of America, an AZ stock company with an administrative office located in Charlotte, NC; and Equitable Distributors, LLC. The obligations of Equitable Financial Life Insurance Company and Equitable Financial Life Insurance Company of America are backed solely by their claims-paying abilities.

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:
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*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: