Send completed forms 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

COLORADO FAMILY AND MEDICAL LEAVE INSURANCE (FAMLI)
EMPLOYEE STATEMENT

Part A: Employee Information (to be completed by the employee requesting leave)

1. Employee's Legal Name (First Name, Middle Initial, Last Name)

2. Employee's mailing address (Street Address (including apt/fl #), City, State, Zip)

Street address

City, State Zip

3. Employee's Social Security Number or TIN

☐☐☐ - ☐☐ - ☐☐☐☐

4. Employee's Date of Birth (mm/dd/yyyy)

5. Employee's Gender
☐ Male ☐ Female
☐ Not Designated/Other

6. Employee's Contact Phone #

(☐☐☐) ☐☐☐ - ☐☐☐☐
area code

7. Employee's Contact Email Address

8. Reason for FAMLI Request (choose ONE option)

☐	Medical leave due to my own serious health condition	☐	Qualifying Military Exigency leave
☐	Bond with my new Child	☐	Safe Leave
☐	Care for my Family Member with a serious health condition	☐	Neonatal Intensive Care leave

9. The Family Member's Relationship* to the Employee (Claimant) is

☐	Self	☐	Grandparent or Spouse's Grandparent
☐	Spouse	☐	Grandchild
☐	Domestic Partner	☐	Sibling or Spouse's Sibling
☐	Parent	☐	Spouse's Parent
☐	Child(Provide Child's age below) Age (years): _____	☐	Child's Spouse

☐ Individual who has a significant personal bond that is or is like a family relationship, regardless of biological or legal relationship, based on the totality of the circumstances surrounding the relationship (affirm & provide detail in a. and b. below)

a. I hereby assert that a family-like relationship exists between _____
(your name)
and. _____
(name of person you have a family-like bond with)

b. Describe how this relationship demonstrates a family relationship: _____

_____

_____

Part A Continued on next page.

COLORADO FAMILY AND MEDICAL LEAVE INSURANCE (FAMLI)

EMPLOYEE STATEMENT

Employee Name: _____ Employee SSN: _____

Employee Address: _____

Part A continued from prior page

Part A: Employee Information - Continued from previous page

11. Will Leave be Utilized Continuously or Intermittently or on a Reduced Leave Schedule? Provide

Details Below. Any changes to your leave plans and/or estimated dates, must be communicated/confirmed as soon as possible to us and your employer.

Continuous Leave:

Continuous uninterrupted period of leave for a single qualifying reason.

Leave Start Date

Enter the first date you are requesting continuous leave leave from work.

☐☐ / ☐☐ / ☐☐☐☐ *month day year*

Leave End Date

Enter the last date you are requesting continuous leave through

☐☐ / ☐☐ / ☐☐☐☐ *month day year*

Intermittent Leave:

Leave in separate, non-consecutive time periods rather than a single span of time for a single qualifying reason

Episodic time off

Dates/hour(s) requested:

Reduced Leave Schedule:

A consistent but reduced work schedule for multiple weeks.

Frequency of leave: (eg: 2 days per week, or 4 hours per day, or every Monday)

12. Was 30 days Advanced Notice Given to Your Employer for this Leave?

☐ **Yes** Date notice provided to employer (mm/dd/yyyy)

☐ **No** → Reason:

Part A Continued on next page

Employee Name: _____ Employee SSN: _____

Employee Address: _____

Part A continued from prior page

Part A: Employee Information - Continued from previous page

13. Have you Received or Claimed any of the Following Benefits in the Preceding 52 weeks? Provide Detail Below.

	Benefit Type	received	claimed	from (mm/dd/yyyy)	through (mm/dd/yyyy)
a.	Unemployment benefits	☐	☐		
b.	Workers' Compensation	☐	☐		
c.	FAMLI	☐	☐		
d.	Other (Sick/Vacation/PTO or other employer provided leave. Please specify.)	☐	☐		

Declaration and Signature

NOTICE It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. I further certify that if benefits are paid in excess of the amount to which I am entitled, I will return to the payor of such benefits, the amount that was overpaid, and I acknowledge that failure to do so may result in the accrual of interest and other penalties.

I am hereby making a request for benefits under the Colorado Family and Medical Leave Insurance program. My signature affirms that the information I am providing is true and accurate to the best of my knowledge and belief.

Signature	**Date** (mm/dd/yyyy)

End of Part A.

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

COLORADO FAMILY AND MEDICAL LEAVE INSURANCE (FAMLI) EMPLOYER STATEMENT

Employee's Legal Name:		**Employee's SSN:**	
Employee's Mailing Address:			

Part B: Employer Information (to be completed by the employer for the above named employee requesting FAMLI)

1. Business's full legal name and mailing address *Business name (including any DBA or Trade Name)*

Street address

City, State Zip

2. Business's Federal Employer Identification Number (FEIN)

3. Employer contact person (Name & Title) for this leave request

4. Employer's contact phone #

( ) - Ext _____
area code

5. Employer contact email address

6. Employee's hire date

/ /
month day year

7. Employee's current employment status
☐ Actively employed-not terminated
☐ Terminated from employment
Date termed: _____ *(mm/dd/yyyy)*

8. Last day worked before leave

/ /
month day year

9. Has the employee returned to work?
☐ Yes ☐ No
Return to work date: _____
☐ Actual ☐ Estimated *(mm/dd/yyyy)*

10. Colorado ("CO") employment verification

a. Are the employee's earnings reported at year end on IRS form W-2? ☐ Yes ☐ No (answer question 10b.)
b. Is the employee subject to Unemployment Insurance obligations in CO? ☐ Yes ☐ No (answer question 10c.)
c. Is the employee's service localized (performed entirely) within CO? ☐ Yes ☐ No (answer question 10d.)
d. If services are not localized, is the employee's base of operations in CO, and some of the work is performed in CO? ☐ Yes ☐ No (answer question 10e.)
e. If there is no base of operations, does the employee perform some of the services within CO and receive direction and control from CO? ☐ Yes ☐ No (answer question 10f.)
f. If there is no place of direction and control, no localized services and no base of operations in CO, does the employee reside in CO? ☐ Yes ☐ No

Part B continues on next page.

Employee's Legal Name:		Employee's SSN:	
Employee's Mailing Address:			

Part B: Employer Information - Continued from previous page

11. Employee's job title

12. Select the days of the week the employee usually works

☐ Mon ☐ Tues ☐ Wed ☐ Thur ☐ Fri ☐ Sat ☐ Sun

13. Taxability

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

What percentage, if any, do you contribute towards the cost of the FAMLI Medical premium? ____%

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

If yes, what percent? _____%

Is it on a ☐ Pre or ☐ Post tax basis?

Note: Paid Family Leave benefits will be treated as 100% taxable and not subject to Federal withholding including Social Security, Medicare, and Federal Income Tax.

13. Provide the employee's earnings history for the prior 5 completed calendar quarters preceding the request for leave

Quarter Ending (mm/yyyy)	Gross Wages ($)

14. Provide the scheduled work hours from the last 4 weeks the employee reported to work prior to the last day worked before leave

Week #	Weekly Hours Worked (e.g. 40 hours)
Week 1	
Week 2	
Week 3	
Week 4	

15. Will Leave be Utilized Continuously or Intermittently or on a Reduced Leave Schedule? Provide Details Below. Any changes to your employee's leave plans and/or estimated dates, must be communicated/confirmed as soon as possible to us.

Continuous Leave:

continuous uninterrupted period of leave for a single qualifying reason.

Leave Start Date
Enter the first date you are requesting continuous leave from work.
☐☐ / ☐☐ / ☐☐
month day year

Leave End Date
Enter the last date you are requesting continuous leave through.
☐☐ / ☐☐ / ☐☐
month day year

Intermittent Leave:

Leave in separate, non-consecutive time periods rather than a single span of time for a single qualifying reason

Episodic time off

Dates requested:

Reduced Leave Schedule:

A consistent but reduced work schedule for multiple weeks.

Frequency of leave: (eg: 2 days per week, or 4 hours per day, or every Monday)

Employee's Legal Name:		Employee's SSN:	
Employee's Mailing Address:			

Part B: Employer Information - Continued from previous page

16. Was 30 days advance given to you by the employee requesting foreseeable leave?

☐ Yes ☐ No Date notice provided to employer (mm/dd/yyyy): _____

Will the employer waive the 30-day advance notice requirement for a foreseeable leave? ☐ Yes ☐ No

17. Has the employee received or claimed any of the following benefits in the preceding 52 weeks?

Provide detail below, and any supporting documentation pertaining to the type of benefit received/claimed.

	Benefit Type	received	claimed	from (mm/dd/yyyy)	through (mm/dd/yyyy)
a.	Unemployment benefits (CESA)	☐	☐		
b.	Workers' Compensation due to work-related injury/illness	☐	☐		
c.	FAMLI	☐	☐		
d.	Other (Sick/Vacation/PTO or other employer provided leave. Please specify. Attach a separate sheet if necessary)	☐	☐		

18. Employer-provided Paid Leave

Will the employee use any employer-provided paid leave during the leave period requested? ☐ Yes ☐ No If yes, provide details on the number of hours employee has available, and list the date(s) this paid time off is applicable for.

Number of hours:_____ Start date: _____ (mm/dd/yyyy) End date:_____ (mm/dd/yyyy)

Are you requesting reimbursement for advance payment of FAMLI benefits? ☐ Yes ☐ No

Note, employer reimbursement is not permitted for any period where the employee is using ACCRUED time to receive full salary (Ex. Sick/Vacation/PTO). Employer reimbursement may be permitted if the employee's salary is being continued through a salary continuation program or other employer-provided leave program (eg. Parental leave).

19. Is the employee taking FMLA concurrently with this leave? Yes ☐ No ☐

Declaration and Signature

NOTICE It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. I am the person authorized to sign as the employer of the employee requesting benefits under the Colorado Family and Medical Leave Insurance program. My signature affirms that to the best of my knowledge the information I have provided is true, accurate, and complete. Any false statements or other failure to provide truthful, accurate and complete information may result in monetary and other penalties as well as the possibility of criminal prosecution.

Signature: **Date:**

EQUITABLE

Equitable Financial Life Insurance Company of America

For Assistance Call (866) 274-9887

COLORADO FAMILY AND MEDICAL LEAVE INSURANCE (FAMLI) NEONATAL CARE LEAVE

Carrier: Equitable Financial Life Insurance Company of America

Address: 8501 IBM Dr, Suite 150-C, Charlotte, NC 28262

Phone: (866) 274-9887
Fax: (315) 477-2499
Email: ebclaims@equitable.com
Portal: equitable.com

Important directions for completing your request for benefits:

To request Neonatal Care Leave benefits under Colorado FAMLI, you must complete this form and return it to us with your Application and other supporting document(s) as described below. Incomplete or missing information may result in a delay in claim processing.

Section 1: Employee/Applicant Information

First name	**Last Name**	**Date of Birth**	**Last 4 Digits of SSN**	**Claim Number** (if known)

Address, City, State, Zip Code

Cell number	**Home Number**	**Work Number**

Section 2: Child Information (this leave is only available for the parent or a person standing in loco parentis to the child)

Child's Name: _____ Child's DOB (mm/dd/yyyy)_____

Name of admitting hospital: _____

Phone number of hospital (include area code):_____

Date of admission: (mm/dd/yyyy): _____/_____/_____ Date of release (mm/dd/yyyy):_____/_____/_____

Note: If your child has been released at the time of this paperwork or you no longer require this leave, it is your responsibility to inform Equitable. Failure to do so may result in retroactive denial and/or an overpayment.

Section 3: Neonatal Care Leave Documentation

Upon request, you will be required to provide a copy of the admission and discharge statements.

Section 4: Employee Certification

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 material fact 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 Colorado 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.

Employee Signature:	Date:

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:**