EQUITABLE

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

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

Massachusetts Paid Family and Medical Leave (PFML) Bonding Instructions

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

This form is required for...

- ✔ **Paid Family and Medical Leave** to bond with a newborn, an adopted child or a foster child

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

- ✖ **Care for a family member with a serious health condition** including a family member with a serious health condition related to military service
- ✖ **Manage affairs** for a family member who is an active service member.
- ✖ **Medical leave due to your own serious health** or conditions due to pregnancy or post-birth recovery that prevent you from working, as certified by a health care provider.

How to use this form

• Employee

1. Complete **Section 1** to tell us about your reason for taking leave.
2. Complete the **Bonding Certification.**
3. Provide **Section 2: Employer Certification of Coverage** to your employer to complete.
4. Complete the **Electronic Funds Transfer (EFT) Request Form**.
5. Send all **completed forms** to:
   Equitable, EB Claims
   8501 IBM Dr, Suite 150-C
   Charlotte, NC 28262
   Fax Number: (315) 477-2499

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

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.

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Massachusetts Paid Family and Medical Leave (PFML)

Application for Bonding Leave

1 Employee Applying for Bonding Leave

Instructions - Complete **Section 1** with your own information.

Your Name:

1. First: _____ Middle: _____ Last:_____
2. (If different) Your name as it appears on official documents like a driver's license or W2:
   First: _____ Middle: _____ Last: _____
3. Phone #: _____
4. Address:
   Street: _____ City: _____ State: _____ Zip:_____
5. Email: _____

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

6. Gender: ☐ Male ☐ Female ☐ Other
7. Marital Status ☐ Married ☐ Single ☐ Widowed
8. Date of birth: _____
   mm/dd/yyyy
9. Last 4 digits of your Social Security Number or Individual Taxpayer ID Number (ITIN):_____

10. Type of Bonding Leave requested:
    ☐ Continuous
    Start Date: _____ End Date: _____ ☐ Dates are estimated
    mm/dd/yyyy mm/dd/yyyy
    ☐ Intermittent (Separate, non-consecutive time)
    Days/Hours Requested:_____ ☐ Dates are estimated
    ☐ Reduced Hours (Consistent, but reduced work schedule for multiple weeks)
    Days/Hours Requested:_____ ☐ Dates are estimated

MA PFML Bonding continued on the next page

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MA PFML Bonding continued from prior

2 Bonding Certification

Instructions - Complete Section 2 with the child's information for which you are requesting leave.

1. Child's Date of Birth: _____
   mm/dd/yyyy
2. Child's Gender: ☐ Male ☐ Female ☐ Not Designated/Other
3. Does the child live with the Employee requesting PFL Bonding Leave? ☐ Yes ☐ No
4. Child is Employee's:
   - ☐ Biological Child
   - ☐ Stepchild
   - ☐ Foster Child
   - ☐ Adopted Child
   - ☐ Spouse/Domestic Partner's Child
   - ☐ Loco parentis
   - ☐ Legal Ward
5. Select one of the following and attach the documentation requested as evidence of the relationship:

Parent of a newborn child:

Birth Mother

- ☐ Health Care Provider certification of pregnancy (include expected due date AND mother's name); OR
- ☐ Health Care provider certification of birth (include date of birth AND mother's name); OR
- ☐ Child's birth certificate

Other Parent:

- ☐ Copy of birth certificate naming second parent; OR
- ☐ Voluntary acknowledgment of paternity; OR
- ☐ Court order of affiliation; OR
- ☐ Birth mother documents (see above) PLUS one of the following:
  - ☐ Marriage Certificate; OR
  - ☐ Certificate of civil union; OR
  - ☐ Evidence of domestic partnership

OR;

- ☐ Other documentation of parental relationship.

Foster Parent:

- ☐ Provide letter of foster care placement or anticipated placement issued by county or city department of Social Services or authorized voluntary foster care agency

Adoptive Parent:

- ☐ Court Order documenting finalization of adoption
- ☐ Documentation in furtherance of adoption

Please provide date of placement, if applicable: _____
mm/dd/yyyy

MA PFML Bonding continued on the next page

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MA PFML Bonding continued from prior

I authorize Equitable Financial Life Insurance Company of America to use the information on this form to determine my eligibility for Bonding Leave. I attest that I am applying for paid leave to bond with a child, and I agree that Equitable can share this information with my employer, and employer affiliates, for the purpose of supporting my application for leave.

MASSACHUSETTS FRAUD NOTICE:
Any person who knowingly and with intent presents a false or fraudulent claim for payment of a loss or benefit, or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

• Employee

Signature

Date (mm/dd/yyyy)

• Employee

Write your name at the top of the remaining pages.
Please have your **Employer** complete **Section 3.**

MA PFML Bonding continued on the next page.

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MA PFML Bonding continued from prior

3 Employer Certification of Coverage

Instructions - This form must be completed by **the Employer**.

1. **Plan/Policyholder Name:** _____

2. **Employee Information:**

Employee/Claimant Name: _____ SSN/TIN: _____

Job Title: _____ Date of Hire:_____

Does this individual meet the definition of a Covered Individual under the Massachusetts Paid Family and Leave Law? ☐ Yes ☐ No

Current Status: ☐ Active ☐ Terminated Date of Termination: _____

Scheduled Work Days: _____ Number of hours per week_____

3. **Taxability** - Please complete with the percentage of PMFL premium paid by each party:

% Employer: _____ % Employee_____ Employee Paid ☐ Pre-Tax ☐ Post Tax

4. **Leave Information:**

Leave Start Date: _____ Date Last Worked: _____

Did the Employee work a full day on their Date Last Worked: ☐ Yes ☐ No

If **No**, how many hours did the Employee work?: _____

Is this Employee on FMLA concurrently with PFL?: ☐ Yes ☐ No

If **Yes**, Type of LOA: ☐ Continuous ☐ Intermittent ☐ Reduced Schedule

If applicable, please advise if the Employee has been approved for MA Paid Family and Medical Leave benefits during the 12 months preceding this period of leave? ☐ Yes ☐ No

If **Yes**, please provide the following:

Leave Type	**From** (mm/dd/yyyy)	**Through** (mm/dd/yyyy)	**Hours Approved**
PFL Bonding			
PFL Care of Family Member with Serious Health Condition			
PFL Military Caregiver Leave			
PFL Qualifying Exigency Leave			
PML Employee Own Serious Health Condition			

MA PFML Bonding continued in next page

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5. **Earnings and Hours Worked - Please complete the following:**
Total Gross Earnings Received and Total Number of Hours Worked, subject to MA PFML Law, by quarter during the base period.

> ***Base Period means:*** *the last four completed calendar quarters immediately preceding the start date of the Paid Family and Medical Leave.*
>
> *If employee has been working for less than the qualifying base period, provide the number of weeks they worked and/or were paid for.*

	CALENDAR QUARTER	TOTAL GROSS EARNINGS	TOTAL HOURS WORKED
1			
2			
3			
4			

Will the employer be making payments to the employee from a qualifying employer sponsored policy or program that are equal to or greater than the MA PFML benefit while on leave? ☐ Yes ☐ No

Will the employer be requesting reimbursement? ☐ Yes ☐ No
If yes, please provide the dates: _____ through _____

Has the employee chosen to receive an accrued paid leave benefit such as PTO or accrued sick leave in lieu of MA Paid Family and Medical Leave benefit *(i.e., not a supplemental payment/top up)?
☐ Yes ☐ No
If yes, please provide the dates: _____ through _____

> **Note: Accrued Paid Leave time is not reimbursable. Employers are required to notify employees that Accrued Paid Leave time runs concurrently with MA Paid Family and Medical Leave and will be decremented from the employee's total Available allotment.*

Completed by: _____ Date: _____
Title: _____
Phone Number: _____ Email: _____

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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:**