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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For Assistance Call (866) 274-9887

Massachusetts Paid Family and Medical Leave (PFML)
Employer Coverage Certification– to be completed by the Employer

Employer - send this completed form to Equitable:

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

Policy/Plan Holder Name: _____

Employee/Claimant Name: _____ Job title: _____

Social Security Number / TIN: _____ Date of Hire: _____
month/day/year

Address: _____
street city state zip

Phone number: _____ Email address: _____

Employment Status: Active_____ Terminated_____ If Terminated provide date of termination: _____

Does this employee meet the definition of an MA Employee/Worker? ☐ Yes ☐ No

Scheduled work days: _____ Number of hours worked per week: _____

Select the days of the week the employee usually works: ☐ Mon ☐ Tue ☐ Wed ☐ Thu ☐ Fri ☐ Sat ☐ Sun

What percentage, if any, do you contribute towards the cost of the Paid Medical Leave premium: _____%

Does the employee contribute toward the cost of the Paid Medical Leave premium? ☐ Yes ☐ No If **Yes**, ____%

Is it on a ☐ Pre-tax basis or ☐ Post-tax basis?

What percent of this employee's Medical Leave benefit is taxable: _____%

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.

PFML leave start date: _____(mm/dd/yyyy) Last Date Worked: _____(mm/dd/yyyy)

Did employee work a full day? ☐ Yes ☐ No If **No**, how many hours did they work? _____

Is the Employee taking FMLA concurrently with PFL? ☐ Yes ☐ No If **Yes**, Leave Type: ☐ Continuous ☐ Intermittent

If applicable, please advise if your employee has been approved for MA Paid Family or Medical Leave benefits at all in the 12 Months preceding the start date of this leave? ☐ Yes ☐ No

If **Yes**, please indicate the type of leave taken and provide the inclusive dates as well as the total time approved:

Leave Type	**From** month/day/year	**Through** month/day/year	**Hours Approved**
PFL Bonding			
PFL Care of Family Member			
PFL Military Caregiver Leave			
PFL Military Exigency			
PML – Employee Own Illness			

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This page is not applicable to Military Exigency leave. Please continue to next page.

Is this employee covered under STD or LTD plans? If so, provide:

STD effective date _____ Prior coverage dates _____
month/day/year

LTD effective date _____ Prior coverage dates _____
month/day/year

What are the employee's physical job demands (pushing, pulling, standing, sitting, etc.):

_____

_____

_____

_____

Are you able to offer job accommodations to facilitate a return to work? ☐ Yes ☐ No

If **Yes**, describe: _____

_____

_____

_____

Is the Employee's condition work related? ☐ Yes ☐ No

If **Yes**, have they applied for WC benefits? ☐ Yes ☐ No

Continued on next page

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Earnings and Hours Worked.
Employer – please complete the grid below using the following guidance:

Total Gross Earnings Received and Total Number of Hours Worked, subject to MA PFML Law, by quarter during the base period.

Base Period means: *the last four completed calendar quarters immediately preceding the start date of the Paid Family and Medical Leave.*

If employee has been working for less than the qualifying base period, provide the number of weeks they worked and/or were paid for.

	CALENDAR QUARTER	TOTAL GROSS EARNINGS	TOTAL HOURS WORKED
1.			
2.			
3.			
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 From _____ Through _____
month/day/year month/day/year

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

If **Yes**, please provide the dates From _____ Through _____
month/day/year month/day/year

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

Completed by: _____ Date: _____

Phone Number: _____ Email: _____

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Electronic Funds Transfer (EFT) Request Form

Clear Form

Instructions

1. Read the Terms and Conditions listed below.

2. Enter your name, address, home telephone number and Employee ID.

3. Complete the bank and account information for your Electronic Funds Transfer request.

4. You and all other parties to the account specified must sign this form.

5. Return the completed form to Claims Office.

Note: Failure to provide the requested information may affect the processing of this form and may delay or prevent the receipt of payments through the EFT Program.

Name: _____

Address: _____

Telephone Number: ( ) - _____

Employee ID: _____

Name of Bank: _____

Bank Address: _____

Bank Telephone Number: ( ) - _____

Type of Account (select one):

Checking: ☐ **Saving:** ☐

Account Number: _____ Account Number: _____

Bank Routing Number: _____

Attach a voided blank personal check.

Indicate any other names on the account selected:

_____

AUTHORIZATION

I / We authorize _____ hereinafter called "The Insurance Company" and/or its Third Party Administrator, hereinafter called "TPA", to initiate credit entries (and to initiate, if necessary, debit entries and adjustments for credit entries made in error) to my (our) account indicated above and the Depository named above, hereinafter called Depository, to credit and/or debit the same to such account. I (we) acknowledge that the origination of ACH transactions to my (our) account must comply with the provisions of U.S. law. This authorization is to remain in full force and effect until The Insurance Company and/or its TPA has received written notice from me (us) of its termination in such time and in such manner as to afford The Insurance Company and/or its TPA and Depository a reasonable opportunity to act on it.

_____ _____

Signature(s): **Date:**

_____ _____

TERMS AND CONDITIONS

The Insurance Company and/or its TPA will not be responsible for any banking fees charged for direct deposit or electronic funds transfer.

I understand that this agreement may be terminated by me upon written notice to The Insurance Company and/or its TPA.

The cancellation will be processed for the time period following receipt of the notice.

I understand that a change in the title of this account which alters the interest of any party terminates this authorization and that a new authorization must then be submitted to continue direct deposit/EFT.

I understand that it is my responsibility to inform The Insurance Company and/or its TPA of any address changes immediately.

I further understand that any benefit payment forwarded to the financial institution covering a period of time after my death will be refunded to The Insurance Company and/or its TPA. I agree that the financial institution shall hathe right of offset for such a refund.

I authorize the financial institution specified in this authorization to provide The Insurance Company and/or its TPA with my home address and the names of any joint account holders for the account specified here in.

I understand that I am responsible for verifying the accuracy of my account data and for promptly notifying The Insurance Company and/or its TPA of any errors or changes including termination of my EFT request.

SPECIAL NOTICE TO OTHER PARTIES TO THIS ACCOUNT.

As a party to this account, I understand that I am personally liable, both individually and as a member of the group of parties to this account, for the full amount of all benefit payments covering any period after the death of the disability benefit recipient. This is a liability to The Insurance Company and/or its TPA. If I am entitled to any benefit as the beneficiary of the disability benefit recipient, the amount of my liability may be deducted from the amount payable to me. I agree that the financial institution shall have the right of offset for such a refund, and I authorize the financial institution to provide The Insurance Company an/or its TPA with my home address.

CANCELLATION

The agreement represented by this authorization remains in effect until cancelled by the recipient by notice to The Insurance Company and/or its TPA or by the death or legal incapacity of the recipient. Upon cancellation by the recipient, the recipient should notify the receiving financial institution that he/she is doing so. The agreement represented by this authorization may be cancelled by the financial institution by providing the recipient a written notice 30 days in advance of the cancellation date. The recipient must immediately notify The Insurance Company and/or its TPA if the authorization is cancelled by the financial institution. The financial institution can not cancel the authorization by advice to The Insurance Company and/or its TPA.

_____ _____

Signature: Date:

I certify that I have read and understand the Terms and Conditions of this EFT Agreement, including the SPECIAL NOTICE TO OTHER PARTIES TO THIS ACCOUNT.

_____ _____

Signature(s) of Other Persons on Account: Date

_____ _____

Date: