Checklist for Requesting Colorado Paid Family and Medical Leave (CO PFML)

Before you apply for CO PFML:

☐ **Check eligibility requirements for leave.**

☐ **Plan your leave.** Leave can be taken continuously, intermittently, or on a reduced leave schedule, in accordance with the CO FAMLI Program and/or private plan PFML policy. The minimum time increment is one (1) hour.

☐ **Notify your CO employer** at least 30 calendar days before the start of leave (if the leave is foreseeable) Otherwise, notify your employer as soon as possible!

Complete your claim form(s) and attach required documentation:

Please print information clearly. Incomplete or illegible claim packages may delay processing.

☐ **Complete Claimant's Statement, in full.** Sign and date the form, retain a copy for your files.

☐ **Your CO employer completes the Employer's Statement, in full.** They should make a copy for their files, and return the completed employer's statement to you.

☐ **Complete the Certification or Attestation for your leave type (options on page 2) and attach supporting documentation as required**.

Submit fully completed claim package and supporting documentation to ShelterPoint or your employer's current CO PFML administrator

Completed claims for CO PFML benefits can be submitted to ShelterPoint by any of the below listed methods (choose one- do not submit by multiple methods). Please **do not** include instruction pages with your submission.

Email: claimforms@shelterpoint.com
Fax: 516-504-6414
Mail: ShelterPoint Life, 1225 Franklin Ave-Ste 475, Garden City NY 11530

Web address: www.shelterpoint.com Phone #: 1-800-365-4999

Important Notes: it is the responsibility of the claimant to submit/file claims with the Carrier, as well as provide any and all required/requested missing information necessary to process the claim. The employer is required to provide the completed employers' statement; **claim determinations and verification of eligibility for benefits will be made by the Carrier.**

Claims should be submitted no later than 30 calendar days after the 1st confirmed day of leave, to avoid losing benefits. If benefits are paid to you in excess of the amount to which you are entitled, you must return the amount overpaid to the payor of such benefits.

By completing and filing your application for Paid Family and Medical Leave benefits, you certify, under penalties of perjury, that to the best of your knowledge and belief, the information contained in the claim package is true, correct, 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.

Checklist for Requesting Colorado Paid Family and Medical Leave (CO PMFL)

Qualifying Leave Types (select one)

NOTE: If utilizing more than 1 type of leave, a separate claim package must be completed for each leave type; leave may not be requested for the same period of time.

☐ **Bonding Leave with a new child** (birth, adoption or foster placement)
- ☐ Complete CO – PFML - BONDING CERTIFICATION form
- ☐ Attach documentation as listed on the form, supporting your relationship with the new child

☐ **Medical Leave due to my own serious health condition** *(including pregnancy/post-partum)*
- ☐ Complete the HIPAA Authorization form and provide it to your health care provider, allowing medical information to be shared with ShelterPoint.
- ☐ Complete the top portion of the CO – PFML - MEDICAL CERTIFICATION – SELF CARE form
- ☐ Your health care provider completes the remainder of the MEDICAL CERTIFICATION – SELF CARE form and returns the completed form to you.

☐ **Caring for a family member with a serious health condition**
- ☐ Your family member completes the HIPAA Authorization form and provides it to their health care provider, allowing medical information to be shared with you and ShelterPoint.
- ☐ Complete the top portion of the CO - MEDICAL CERTIFICATION – FAMILY CARE form, providing information on yourself and your qualifying family member requiring care
- ☐ Your family members health care provider completes the remainder of the CO - MEDICAL CERTIFICATION – FAMILY CARE form and returns the completed form to you.

☐ **Qualifying exigencies associated with a call to active duty overseas**
- ☐ Complete the CO – PFML - MILITARY EXIGENCY ATTESTATION form
- ☐ Attach proof documents supporting the leave (options listed on the form)

☐ **Safe Leave**

If you or your family member are victims of domestic violence, sexual assault or abuse, harassment, or stalking, you may be eligible to receive up to 12 weeks of CO PFML benefits to seek medical or psychological care, to seek support from a victim services organization, to relocate, or to participate in any civil or criminal proceeding(s).

- ☐ Complete the CO – PFML – SAFE LEAVE ATTESTATION form

End of CO PFML Claim Checklist

Request for Colorado Paid Family and Medical Leave (PFML)

ShelterPoint Life Insurance Company

Claim Number:

CLAIMANT STATEMENT

This Application ("Claimant Statement") is completed by the individual that is requesting paid leave benefits (the "Claimant" or "Employee"). Applications may be filed up to 30 days prior to the start of the requested leave, and up to 30 days after the start of the leave. A fully complete application for benefits includes a Claimant statement, employer statement, certification/attestation relating to the type of leave being requested, and supporting proof documentation for the leave. Claims filed outside this window will be denied unless good cause is provided for late filing. Claim filing is the responsibility of the individual that is requesting paid leave benefits. The claimant is responsible for providing any missing or additional requested information during the claim process and is responsible for informing all required parties of any changes to leave plans.

PRINT CLEARLY IN BLUE OR BLACK INK. Missing or incomplete information may delay processing.

Demographic Information

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

First name | *Middle initial* | *Last Name*

2. Claimant's Mailing Address (Street Address (including apt/fl #), City, State, Zip):

Street address

City, State Zip

3. Claimant's Social Security Number or I-TIN:

☐☐☐ - ☐☐ - ☐☐☐☐

4. Claimant's Date of Birth:

☐☐ / ☐☐ / ☐☐☐☐

MONTH DAY YEAR

5. Claimant's Gender:

☐ Male
☐ Female
☐ Not Designated/Other

6. Claimant's Primary Contact Phone Number & Type:

(☐☐☐) ☐☐☐ - ☐☐☐☐

area code

☐ Mobile/Cellular Phone ☐ Home Phone ☐ Work Phone

7. Claimant's Contact Email Address:

By providing your contact information, you consent to Us contacting you by any of the methods provided.

Leave Information

8. Reason for PFML Request (choose ONE option):

☐	Medical leave due to **my own** serious health condition
☐	Bond with my new Child
☐	Care for my Family Member with a serious health condition
☐	Safe Leave for myself or my family member due to domestic violence, harassment, sexual assault, or stalking
☐	Military Exigency

9. Family Member's Relationship* to the Claimant is:

* "Relationship" includes "biological, foster, adoptive, step, and in loco parentis relationships and the same relationships to the Claimant's spouse or domestic partner, if applicable.

☐	Self	☐	Child
☐	Spouse	☐	Grandparent
☐	Domestic Partner	☐	Grandchild
☐	Parent	☐	Sibling

☐ 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: _____

_____

_____

_____

_____

Form continues on next page

Claimant Name: _____ Claimant SSN: ☐☐☐-☐☐-☐☐☐☐

Claimant Address: _____

Leave Information (continued from previous page)

10. Leave Pattern and Period(s) Requested:

Indicate whether leave will be taken continuously (all at once), or intermittently. Provide your leave dates and schedule, giving as much detail as possible. *Any changes to your leave plans and/or estimated dates, must be communicated to Us (and your employer) as soon as possible. You may not request any leave prior to the start of the CO PFML program (01/01/2024) Or the effective date of your Employer's Plan, whichever is later.*

☐ **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

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

Date(s) & Hour(s) Requested:

☐ **Reduced Leave Schedule:**

A consistent but reduced work schedule for multiple weeks. Minimum time increment (1) hour

Leave Start Date
Enter the first date you are requesting REDUCED LEAVE from work.
☐☐ / ☐☐ / ☐☐☐☐ (month / day / year)

Frequency of leave: (e.g., 4 hours per day or 2 days per week. Be specific)

11. Notice to Employer:

Foreseeable leave (*a qualifying event such as a planned medical procedure/treatment for yourself/your qualified family member, or for the birth of/placement of a new child*) requires advance notice to your employer. Unforeseeable leave (*emergency basis or unexpected*) requires notice to your employer as soon as practicable.

a. **Was 30 day's advanced notice provided to your employer for this leave?** ☐ **Yes** ☐ **No**

b. **Date notice was provided to employer**: ☐☐ / ☐☐ / ☐☐☐☐ (month / day / year)

c. **If 30 day's advance notice was not provided, explain why:**

_____

_____

_____

_____

12. Other Types of Leave:

Provide detail on other types of benefits/leave taken or requested in the preceding 52 weeks, and whether it will extend through the current requested leave period covered by this claim

	Benefit Type	received	claimed	from (mm/dd/yyyy)	through (mm/dd/yyyy)
a.	Unemployment benefits (CSEA)	☐	☐		-
b.	Workers' Compensation	☐	☐		-
c.	CO FAMLI/PFML	☐	☐		-

Form continues on next page

Claimant Name: _____ Claimant SSN: ☐☐☐-☐☐-☐☐☐☐

laimant Address: _____

Employment Information

Provide information on your employment history in **Colorado**. This information will be verified with your employer. Do not include employment history outside of Colorado.

KEY TERMS:

Benefit year: Has the same meaning as application year as defined in C.R.S 8-13.3-503(1) and as described in C.R.S. 8-13.3-521(1)(b) means the 12-month period beginning on the first day of the calendar week in which an individual's benefit start date occurs.

Base period: the first four of the last five completed calendar quarters preceding the benefit year.

Wages: Includes but not limited to: Salary, hourly wage, overtime, tips, bonuses, commissions, piece rate, PTO, sick, or vacation time, disability benefits paid by employer ***not*** a third party, parental leave paid by employer ***not*** a third party, and the value of lodging or meals used as a credit toward minimum wage.

Wages does not include: Severance pay, deferred compensation contributions or payments, profit-sharing, pensions or retirement payment plans, expense reimbursement (mileage, travel, moving, per diems, etc.), non-monetary payments (except lodging or meals to the extent they're used as a credit towards minimum wage).

Example: *Cindy requests CO PFML bonding leave with a leave start date of **01/17/2024**. Her benefit year will begin on 01/17/2024. Cindy's base period for reporting wages is the **first (4)** of the **previous (5) completed quarters**. Based on her start date, the lookback quarters are 1. 10/1-12/2022 2. 01/01 – 03/2023 3. 04/1 – 06/2023 4. 07/1 – 09/2023 5. 10/01 – 12/2023. The gross wages from the **highest quarter** during these first 4 quarters (10/1/2022-09/30/2024) will be used to determine her average weekly wage (AWW).*

Cindy's highest quarter earnings during the base period were in Q4 2022 when she earned $14,000.00, making her AWW $1,076.92. This AWW will be used to calculate her weekly benefit rate under CO PFML.

13. Give the Name and Details of Your Recent Employer(s):

If you had more than one employer in the base period (the first four of the last five completed calendar quarters preceding the benefit year), name all employers. Looking back to the previous 4 of the last 5 completed quarters prior to your application for leave, determine the quarter in which your wages were highest, and report that value in the "Gross Wages" column. You may be asked to provide supporting documentation of wages. Average hours and days worked per week is based off your Regular Work Schedule, averaged from the 4 weeks prior to your last day worked before leave.

Most Recent Employer

Business Name, Address/City/St/Zip, Tax ID #	Avg # hours/week (e.g. 40 hrs/wk)	Avg # days/week (e.g. 5 days/wk)	Employment date(s) (MM/DD/YYYY)	Days of the Week usually worked:	Gross ($) Wages in Base Period
			Hire Date: **Last Day Worked:**	☐Mo ☐Tu ☐We ☐Th ☐Fr ☐Sa ☐Su - - - - - - - - - - - - - - - - - ☐ Schedule Varies	

Other CO Employer(s)

If more than 3 recent CO Employers, please include details on a separate sheet.

Business Name, Address/City/St/Zip, Tax ID #	Avg # hours/week (e.g. 40 hrs/wk)	Avg # days/week (e.g. 5 days/wk)	Employment date(s) (MM/DD/YYYY)	Days of the Week usually worked:	Gross ($) Wages in Base Period
			Hire Date: **Last Day Worked:**	☐Mo ☐Tu ☐We ☐Th ☐Fr ☐Sa ☐Su - - - - - - - - - - - - - - - - - ☐ Schedule Varies	
Business Name, Address/City/St/Zip, Tax ID #	**Avg # hours/week** (e.g. 40 hrs/wk)	**Avg # days/week** (e.g. 5 days/wk)	**Employment date(s)** (MM/DD/YYYY)	**Days of the Week usually worked:**	**Gross ($) Wages in Base Period**
			Hire Date: **Last Day Worked:**	☐Mo ☐Tu ☐We ☐Th ☐Fr ☐Sa ☐Su - - - - - - - - - - - - - - - - - ☐ Schedule Varies	

Form continues on next page

Claimant Name: _____ Claimant SSN: ☐☐☐-☐☐-☐☐☐☐

Claimant Address: _____

Benefit Payment Preferences

Disclosure Statement: Information regarding PFML benefits received by the employee, such as payments received and leave schedule, will be provided to the employer.

14. Please choose your preference for receiving benefit payments. Certain options may not be available depending on the leave pattern or benefit recipient. If your claim does not qualify for ACH/direct deposit, your benefit payments will automatically be issued via paper check. A completed enrollment form is required to participate in direct deposit and proof of account information is required (e.g. a copy of a voided check from the issuing bank, or a written statement from the banking institution verifying account details).

☐ Paper Check
☐ Direct Deposit

Attestation 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 attest 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 Signed**
	☐☐ / ☐☐ / ☐☐☐☐ *month* *day* *year*

End of CO PFML - Claimant Statement.

Request for Colorado Paid Family and Medical Leave (PFML)

EMPLOYER STATEMENT

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

Employer Information (to be completed by the employer for the above named employee requesting CO PFML)

PRINT CLEARLY IN BLUE OR BLACK INK. Missing or incomplete responses may delay processing.

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 Provide the employee's ***current date of hire***.

☐☐ / ☐☐ / ☐☐☐☐

month / *day* / *year*

7. Employee's current employment status

☐ Actively employed-not terminated

☐ Terminated from employment (provide date below)

Date Terminated

☐☐ / ☐☐ / ☐☐☐☐

month / *day* / *year*

8. Last day worked before leave

☐☐ / ☐☐ / ☐☐☐☐

month / *day* / *year*

9. Has the employee returned to work?

☐ Yes ☐ No

Return to work date: ☐☐ / ☐☐ / ☐☐☐☐

month / *day* / *year*

☐ Actual ☐ Estimated

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

Form continues on next page

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

Employer Information- Continued from previous page

11. Employee's job title

12. Employee's normal working schedule and hours worked

a. Select the days of the week the employee usually works and list the average number of work days per week.

Average # of work days per work week: _____

☐ Mon ☐ Tue ☐ Wed ☐ Thur ☐ Fri ☐ Sat ☐ Sun

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

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

13. Provide the employee's wages during the base period:

"Wages" include, but are not limited to, salary, wages, tips, commissions, and other compensation as determined by the director by rule.

*"Base period" means the first four of the last five **completed calendar quarters** immediately preceding the first day of the individual's benefit year.*

"Benefit Year" has the same meaning as application year as defined in C.R.S 8-13.3-503(1) and as described in C.R.S. 8-13.3-521(1)(b) means the 12-month period beginning on the first day of the calendar week in which an individual's benefit start date occurs.

	Base period wages	Quarter Ending Date (mm/yyyy)	Wages ($)
base period	Quarter 1		
	Quarter 2		
	Quarter 3		
	Quarter 4		
	Quarter 5 (most recent)		

14. 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 the EE is requesting continuous leave from work.
month / day / year

Leave End Date
Enter the last date the EE is 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

Leave Start Date
Enter the first date the EE is requesting intermittent leave from work.
month / day / year

List all dates/hours requested:

☐**Reduced Leave Schedule:**

A consistent but reduced work schedule for multiple weeks.

Leave Start Date
Enter the first date the EE is requesting reduced leave from work.
month / day / year

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

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

☐ Yes ☐ No

Date notice provided to employer
month / day / year

Detail:

Will the employer waive the 30 day advance notice requirement for a foreseeable leave?

☐ Yes ☐ No

Form continues on next page

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

Employer Information - Continued from previous page

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.	CO PFML/FAMLI	☐	☐		-
d.	Other (Sick/Vacation/PTO or other employer provided leave. Please specify. Attach a separate sheet if necessary)	☐	☐		-

18. Employer-provided Paid Leave during leave period

An employee cannot receive both wage replacement benefits under the FAMLI Act and employer-provided paid leave for the same hours absent, except that pursuant to C.R.S. 8-13.3-510(1)(c), an employer and an employee may mutually agree that the employee may use any **accrued employer-provided leave** as a **supplement** to family and medical leave insurance benefits in an amount not to exceed the difference between the individual's wage replacement benefits under the FAMLI Act and the individual's average weekly wage.

"**Employer-provided paid leave**" means vacation leave, paid sick leave, paid personal leave, paid parental leave, paid leave under C.R.S. 24-34-402.7, and any other employer-paid time off, except that employer-provided paid leave does not include benefits under a commercial short-term or long-term disability policy for purposes of these rules.

a. Will the employee be using any employer-provided paid leave **during the leave period requested**?
☐ Yes (answer question b) ☐ No (go to question # 19)

b. Will the employee be receiving wage replacement **during all or a portion of the leave period requested?**
☐ Yes – (answer question i and ii) ☐ No (go to question # 19)

i. provide detail on type of wage replacement and the date(s) it will be paid for:

ii. are you requesting reimbursement* for advance payment of FAMLI benefits? ☐ Yes ☐ No

Note:
Employer reimbursement may be permitted if the employee's salary is being continued through some kinds of benefits payments made by the employer. Employer reimbursement is **not permitted** if the employee is using **any employer-provided paid leave** such as use of accrued vacation, sick, personal or parental leave.

19. CO PFML Policy #:

Attestation 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.

Signature	Date (mm/dd/yyyy)
	☐☐ / ☐☐ / ☐☐☐☐ (month / day / year)

End of CO PFML Employer Statement.

ShelterPoint Life Insurance Company
1225 Franklin Avenue, Ste. 475
Garden City, NY 11530
Fax: 516.504.6412 (main) | 516.504.6436 (service) | 516.504.6414 (claims)
Phone: 800.365.4999 (516.829.8100)
www.shelterpoint.com

HIPAA AUTHORIZATION FOR USE AND DISCLOSURE OF INFORMATION

Instructions: The individual who requires care completes this form, and provides a completed copy to their health care provider. For medical leave due to **your own serious health condition**, you may complete this form and provide a copy to your health care provider along with the Medical Certification form. For leaves **to care for your qualified family member with a serious health condition**, the family member who requires care ("Care Recipient") should complete the form in its entirety, sign, and date, and provide to their health care provider along with the Medical Certification form. Retain a copy of the completed form for your records.

Care Recipient Information (completed by the individual requiring care)

1. Name of Individual to Receive Care ("Care Recipient") (First Name, Middle Initial, Last Name)

First name | *Middle initial* | *Last name*

2. Mailing Address of Individual Receiving Care (Street Address (including apt/fl #), City, State, Zip):

Street address

City, State Zip

3. Care Recipient's Contact Phone #:

( ) -

area code

4. Care Recipient's Date of Birth:

/ /

MONTH DAY YEAR

Health Care Provider Information

5. Name of Care Recipient's Health Care Provider (include full professional designation, i.e. MD, DO):

6. Mailing Address of Health Care Provider (Street Address (including apt/fl #), City, State, Zip):

Street address

City, State Zip

7. Health Care Provider's Contact Phone #:

( ) -

area code

Authorization

I _____ authorize _____ to

print full name of care recipient *insert name of health care provider above ("Health Care Provider")*

complete the Medical Certification and disclose Protected Health Information ("PHI") relating to my medical condition for which the medical certification and PFML is being requested to the paid family and medical leave (" PFML") insurance carrier listed below.

Carrier Name: SHELTERPOINT LIFE INSURANCE COMPANY
Carrier Address: 1225 Franklin Avenue, Suite 475, Garden City NY 11530

Unless I have put a check by the information that may be disclosed, I do NOT want my Health Care Provider to disclose the following types of information:

☐ HIV/AIDS related information;
☐ Mental health information;
☐ Substance Abuse information;
☐ Psychotherapy notes

HIPAA Authorization continues on the next page.

Continued from previous page

Acknowledgements

I understand that:

a. This Authorization is voluntary.
b. My treatment and the payment for my treatment will not be affected by my signing or not signing this Authorization;
c. This authorization will expire one year from the date I sign below, unless otherwise revoked;
d. I may revoke this Authorization at any time by notifying the Health Care Provider in writing, but the revocation will not apply to information that has already been disclosed;
e. The information that is disclosed pursuant to this Authorization may be re-disclosed by the recipient and no longer protected; and,
f. I may request a copy of this Authorization and shall provide a copy to ShelterPoint.

Signature (Page 1 of this form must be completed before signing below)

Signature of Care Recipient or Care Recipient's Legal Representative:	**Date Signed:** ☐☐ / ☐☐ / ☐☐☐☐ MONTH DAY YEAR

If signed by Care Recipient's Legal Representative, complete the following:

Printed Name of Care Recipient's Legal Representative:

Relationship of Care Recipient to the Legal Representative:

Please Check which of the following provides authority to serve as a Legal representative:

☐ Parental right;
☐ Power of attorney (attach copy)
☐ Health care proxy (attach copy)
☐ Court order (attach copy)

End of HIPAA Authorization

ShelterPoint Life Insurance Company

Request for Colorado Paid Family and Medical Leave (PFML)

Claim Number:

MEDICAL CERTIFICATION – FAMILY CARE LEAVE
(Serious Health Condition Certification– Family Member)

Family Care Leave allows a covered individual to take leave from employment to care for their qualified family member with a serious health condition. An individual may not exceed 12 weeks of paid leave in a benefit year. Applications may be filed up to 30 days prior to the start of the requested leave, and up to 30 days after the start of the leave. Claim filing is the responsibility of the individual that is requesting paid leave benefits ("Claimant" or "Employee"). The claimant is responsible for providing any missing or additional requested information during the claim process and is responsible for informing all required parties of any changes to leave plans.

Claimant Information (to be completed by the Claimant requesting family leave)

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

First name | *Middle initial* | *Last name*

2. Claimant's Mailing Address (Street Address (including apt/fl #), City, State, Zip):

Street address

City, State Zip

3. Claimant's Social Security Number or TIN:

☐☐☐ - ☐☐ - ☐☐☐☐

4. Claimant's Date of Birth:

☐☐ / ☐☐ / ☐☐☐☐
MONTH DAY YEAR

5. Claimant's Gender:

☐ Male
☐ Female
☐ Not Designated/Other

Family Member Information (covered family member requiring care due to their health condition)

1. Family Member's Legal Name (First Name, Last Name):

First Name | *Last Name*

2. Family Member's Date of Birth:

☐☐ / ☐☐ / ☐☐☐☐
MONTH DAY YEAR

3. Family Member's Mailing Address

Street address

City, State Zip

4. The Family Member's Relationship* to Claimant:

☐ Child ☐ Spouse ☐ Domestic Partner ☐ Parent ☐ Grandparent ☐ Grandchild ☐ Sibling
☐ Person with whom the employee has a significant bond that is or is like a family relationship

**Relationships include "biological, foster, adoptive, step, and in loco parentis relationships and the same relationships to the employee's spouse or domestic partner, if applicable.*

MEDICAL CERTIFICATION (to be completed by the family member's treating health care provider)

A family member of your patient has made a request to be absent from work to care for your patient. For us to make a decision on their claim for CO Paid Family and Medical Leave benefits for the care of your patient, we will need you to complete the information in this form. When completing this certification, we ask:

- Your answers are to be your best estimate based on your medical knowledge, experience, and examination of the patient.
  - Please note, health care providers may only certify the need for leave if such certification is within the diagnostic scope of their licensure, certification, or registration (7 CCR 1107 – 3.2.12).
  - Health care providers cannot certify their own serious health condition, or their family member's serious health conditions (7 CCR 1107 – 3.6.7).
- Be as specific as you can. Using terms like "as needed", "unknown" or "indeterminate" may not be enough to approve the claim.
- Limit your responses to the health condition for which their family member is seeking leave.

Do not include information about genetic tests, as defined in 29 C.F.R. § 1635.3(f), genetic services, as defined in 29 C.F.R. § 1635.3(e), or the manifestation of disease or disorder in the employee's family members, 29 C.F.R. §1635.3(b).

Serious Health Condition: means an illness, injury, impairment, pregnancy, recovery from childbirth, or physical or mental condition that involves inpatient care in a hospital, hospice or residential medical care facility, or continuing treatment by a Health-Care Provider.

Form continues on next page

Claimant Name: _____ Claimant SSN: ☐☐☐-☐☐-☐☐☐☐

Patient's Name:_____ Patient's DOB: ☐☐ / ☐☐ / ☐☐☐☐
MONTH DAY YEAR

Continued from prior page

MEDICAL CERTIFICATION (to be completed by the family member's treating health care provider)

1. Medical Information:

a.	What was the **first date** on which the patient's health condition commenced?	☐☐ / ☐☐ / ☐☐☐☐ (month / day / year)
b.	What is the probable duration of the health condition? (e.g., 3 months; 2 weeks)	
c.	For the health condition for which your patient is requesting time away from work, is it your belief that the health condition was caused by or otherwise related to a workplace injury or illness?	☐ Yes ☐ No

d. Which of the following apply to the patient's health condition? **Check all that apply and provide specifics regarding dates.**

☐ **Inpatient Care –**
The patient ☐was/☐is/☐will be admitted for an **overnight stay** in a hospital, hospice, or residential medical care facility on the following dates:
- Admit Date(s):_____
- Discharge Date(s)_____

☐ **Incapacity Plus Treatment** *(e.g., outpatient surgery, strep throat)* Answer i. through iii. below

☐ i. Due to the patient's health condition, the patient ☐was/☐is/☐will be incapacitated for more than three consecutive, full calendar days

☐ ii. The patient ☐was/☐is/☐will be seen on the following date(s):

Visit/Treatment Date(s): _____

☐ iii. The health condition ☐had/☐has/☐will also result(ed) in a course of continuing treatment under the supervision of a health care provider *(e.g., prescription medication (other than over the counter), therapy requiring special equipment, etc.)*

☐ **Pregnancy -** The health condition is pregnancy

☐ **Chronic Health Conditions -** *(e.g., asthma, migraine headaches)* Treatment visits are expected to be at least twice per year

☐ **Permanent or Long-Term Health Conditions -** Due to the health condition, incapacity is permanent or long term and requires the continuing supervision of a health care provider (even if active treatment is not being provided).

☐ **Health Conditions requiring Multiple Treatments -** *(e.g., chemotherapy treatments, restorative surgery, etc.)* Due to the health condition, it is medically necessary for the patient to receive multiple treatments.

☐ **None of the above -** If none of the above six categories is checked, *(i.e., inpatient care, pregnancy)* no additional information is needed. Please sign and date the form on page 3.

2. Diagnosis/Analysis: Provide the relevant medical facts relating to the health condition requiring this leave (these facts may include diagnosis, symptoms, or any regimen of continuing treatment such as the use of specialized equipment):

Diagnosis code(s):

Signs & symptoms:

Objective findings:

3. Care Needs of the Patient: To qualify for benefits, care of the patient must be medically necessary. Select the type of care needed by the patient or provide a brief description in the space below (e.g., assistance with basic medical, hygienic, nutritional, safety, transportation needs, physical care, or psychological comfort).

☐Assistance with basic medical, hygienic, nutritional, or safety needs ☐Physical care ☐Psychological comfort ☐Transportation
☐Other (please describe):

Form continues on next page

Claimant Name: _____ Claimant SSN: ☐☐☐-☐☐-☐☐☐☐

Patient's Name:_____ Patient's DOB: ☐☐ / ☐☐ / ☐☐☐☐
MONTH DAY YEAR

Continued from previous page

MEDICAL CERTIFICATION - (to be completed by the family member's treating health care provider)

4. Medical Leave Needed: Indicate whether your patient will require leave from work on a continuous, intermittent, or reduced work schedule basis. If intermittent, provide detail of the frequency of leave needed, and approximate duration per episode. Check all that apply.

☐ **Continuous Leave** My patient has/will be incapacitated for a single continuous period due to their own health condition, including time for treatment and recovery	**Start Date**	**End Date**	
☐ **Reduced Work Schedule Leave** My patient will need to work a reduced work schedule due to their own health condition and associated treatment and recovery period	**Start Date**	**End Date**	**Work Capacity**
			The patient is able to work up to ____ hours per week.
☐ **Intermittent Leave** My patient is expected to have periodic flare-ups or follow-up treatment appointments where intermittent absence from work will be medically necessary	**Start Date**	**End Date**	**Incapacity**
			The Patient's incapacity may occur up to ____ hours per week.

5. Health Care Provider Information: Please **print** all requested information legibly, then sign and date the form. Retain a copy of the completed form for your files and return the original to the patient.

Health Care Provider's First & Last Name:		Professional Designation: (e.g., MD, DO, PA, CNM)	
Phone Number:		Specialty/Board Certification:	
Fax Number:		License Number and State:	
Business Address: (Practice name, Street address, City, State, Zip)		National Provider Identifier (NPI) Number:	

Certification 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.*

My signature certifies that the information provided in this form is true and correct, that I have examined the patient and answered the questions accurately and to the best of my ability, that I am a health care provider authorized to certify their health condition within the scope of my licensure, and that the patient is not one of my family members.

Health Care Provider's Signature	**Date Signed** ☐☐ / ☐☐ / ☐☐☐☐ MONTH DAY YEAR

End of CO PFML – Medical Certification – Family Care form

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Direct Deposit Enrollment and Authorization Form for Colorado Paid Family and Medical Leave (CO PFML)

INSTRUCTIONS

PLEASE PRINT ALL INFORMATION CLEARLY IN BLUE OR BLACK INK. This form must be fully completed, signed, and dated to be valid. Incomplete or ineligible submissions are unable to be processed and will not be accepted.

Eligibility for Direct Deposit: ShelterPoint Life Insurance Company (the "Company") offers Direct Deposit Payments on Colorado Paid Family and Medical Leave claims where benefit payments are being issued directly to the claimant/employee. Direct Deposit is not available if benefits are being issued to the Employer. In the event that a direct deposit payment is rejected, the rejected payment and any future benefit payments due under the claim will be issued via check until the bank information is corrected and an updated Enrollment and Authorization Form is submitted.

Required information: you must supply all requested information on this form. Fully completed, signed and dated forms may be sent to ShelterPoint by any of the below listed methods:

- Upload your completed form via www.shelterpoint.com
- Email to: claimforms@shelterpoint.com
- Fax to: 516-504-6414
- Mail to: ShelterPoint Life, 1225 Franklin Avenue-Ste 475, Garden City NY 11530

If you have any questions regarding this form, contact our Customer Service Department at 1-800-365-4999.
Please allow up to 10 business days for set up of your direct deposit request.

REQUIRED INFORMATION (please print all information CLEARLY)

1. Claimant Name (First name, Last name)

2. Social Security Number or I-TIN

☐☐☐ - ☐☐ - ☐☐☐☐

3. ShelterPoint Claim Number(s)

4. Account Type

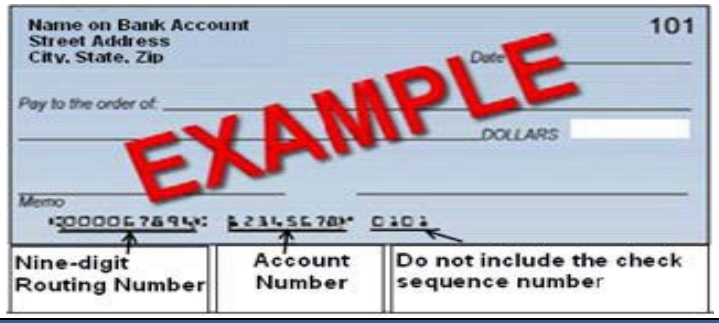
☐ Checking Account ☐ Savings Account

5. Banking Information

Bank Name: _____

Bank Routing Number (ABA#):_____

Bank Account Number: _____



ATTACH PROOF OF BANKING INFORMATION

Attach proof of banking information to this authorization form. Examples of valid proof include, but are not limited to the following:

- a copy of a voided check with your name, bank name, routing # and account # listed; or
- a written statement from your bank confirming account holder name, bank name, routing # and account #

Failing to include proof of banking information may result in direct deposit not being established under an approved claim.

AUTHORIZATION AND SIGNATURE

I authorize ShelterPoint Life Insurance Company ("Company") to deposit any benefits I am eligible to receive directly into the account and bank I have indicated above or to such other account as the bank or any successor bank designates as my account. I also authorize the Company to debit my account for any deposits made in error, or the Company reserves the right to request the return of such funds through other mechanisms. I also understand that the direct deposit service will stay in effect until I notify the Company in writing of cancellation or until I am no longer eligible for or due payments, whichever comes first. If you are also covered under another ShelterPoint Disability / Paid Leave/ PFML policy, this request will also apply to those coverages / claims, if applicable, and should they be approved.

☐ Check this box if you **do not** want to receive paper EOBs in the mail if your direct deposit request is approved.

Claimant Signature

Date (mm/dd/yyyy)

☐☐ / ☐☐ / ☐☐☐☐
month day year