# Request for Massachusetts Paid Family and Medical Leave (PFML)

## Checklist for Requesting Massachusetts Paid Family and Medical Leave

## *Before you apply:*

☐ Check eligibility requirements for Paid Family and Medical leave. https://www.mass.gov/info-details/your-eligibility-for-paid-family-and-medical-leave-pfml

☐ Plan your leave. Leave can be taken continuously, intermittently, or on a reduced leave schedule, in accordance with MA PFML regulation.

☐ Notify your employer at least 30 days before the start of leave (if it is foreseeable); otherwise notify your employer as soon as possible

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

☐ Complete Part A, Claimant Statement, in full. Please print clearly. Make a copy, and give the claim package to your employer to complete Part B.

☐ Your employer completes Part B, Employer Statement, in full, makes a copy for their files, and returns the completed form to you.

☐ Complete the certification for your leave type, and attach supporting documentation

| Medical leave-Self | Bonding | Military Exigency |
|---|---|---|
| ☐ complete the HIPAA Authorization form and provide it to your doctor, allowing medical information to be shared with ShelterPoint | ☐ complete the entire Bonding Certification form | ☐ complete the entire Military Exigency form |
| ☐ complete the top portion of the Medical Certification- Self form | ☐ attach proof document supporting the leave | ☐ attach proof document supporting the leave |
| ☐ Your provider completes the remainder of the Medical Certification-Self form, and returns to you. | | |

**Military Caregiving or Family Care* (*available 7/1/21)**

☐ your family member needs to complete the HIPAA Authorization form and provide it to their doctor, allowing medical information to be shared with you and ShelterPoint.

☐ Complete the top portion of the Medical Certification- Military Caregiving or Family Care form, providing information on yourself and your qualifying family member requiring care.

☐ Your family member's provider completes the remainder of the Medical Certification form, and returns to you in a timely fashion.

## *Submit to ShelterPoint or your employer's current PFML carrier:*

Completed claims for MA 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 (size of email & attachments cannot exceed 10MB)
**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

SHELTERPOINT
ShelterPoint Life Insurance Company

# Request for Massachusetts Paid Family and Medical Leave (PFML)

MASSACHUSETTS

## 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 PFML Request**

☐ Medical leave due to my own serious health condition

☐ Bond with Child

☐ Care for Family Member with serious health condition*
(*available for leaves starting on or after 7/1/21 only)

☐ Care for a family member who is a Covered Service Member of the Armed Forces with serious health condition related to active service.

☐ Qualifying Military Exigency

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

☐ Self
☐ Spouse
☐ Domestic Partner
☐ Child
☐ Parent
☐ Parent-in-Law
☐ Grandparent
☐ Grandchild
☐ Sibling

**10. Give the name and details of your last employer.** *If you had more than one employer in the past 12 months, name all employers. Wages is your sum total of gross wages in the 12-month period prior to your application for leave, for that employer.*

| Most recent employer | Employment date(s) | | Avg # hours worked/week | Avg # days worked/wk | Avg wages |
|---|---|---|---|---|---|
| Business Name & Address | hire date (m/d/yy) | last day worked (m/d/yy) | | | |
| | | | | | |
| **Other employer(s) during past 12 month period** | **Employment date(s)** | | **Avg # hours worked/week** | **Avg # days worked/wk** | **Avg wages** |
| **Business Name & Address** | **hire date (m/d/yy)** | **last day worked (m/d/yy)** | | | |
| | | | | | |
| | | | | | |

Part A continues on next page.

Employee Name: _____ Employee SSN:_____

Employee Address: _____

## 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.*

| | Start date (mm/dd/yyyy) | Through (mm/dd/yyyy) |
|---|---|---|
| Continuous Leave: | | |
| Intermittent Leave: *Episodic time off* | Dates requested: | |
| Reduced Leave Schedule: *A consistent but reduced 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:

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

| | Benefit Type | received | claimed | from (m/d/yy) | through (m/d/yy) |
|---|---|---|---|---|---|
| a. | Unemployment benefits | ☐ | ☐ | | - |
| b. | Workers' Compensation | ☐ | ☐ | | - |
| c. | PFML | ☐ | ☐ | | - |
| d. | Other (Sick/Vacation/PTO or other employer provided leave. Please specify.) | ☐ | ☐ | | - |

**Declaration and Signature**

***NOTICE*** Any person who knowingly 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.

I am hereby making a request for benefits under the Massachusetts Paid Family and Medical Leave Law. 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.

SHELTERPOINT
ShelterPoint Life Insurance Company

# Request for Massachusetts Paid Family and Medical Leave (PFML)

| | | | |
|---|---|---|---|
| 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 PFML)

**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**

☐☐ - ☐☐☐☐☐☐☐

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

**4. Employer's contact phone #**

( ☐☐☐ ) ☐☐☐ - ☐☐☐☐ Ext: _____

*area code*

**5. Employer contact email address**

**6. Reason for PFML Request**

☐ Medical leave due to employee's own serious health condition

☐ Bond with Child

☐ Care for Family Member with serious health condition*
(*available for leaves starting on or after 7/1/21)

☐ Care for a family member who is a Covered Service Member with serious health condition related to active service.

☐ Qualifying Military Exigency

**7. Status of PFML request with the employer**

☐ Approved

☐ Denied

☐ Pending receipt of additional information

Provide detail as necessary.

**8. Provide the employee's earnings history for the prior 4 completed calendar quarters preceding the request for leave**

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

***Average*** _____

**9. Usual work schedule, hours worked, and location of work**

| | | weekly amount |
|---|---|---|
| 9a. | Average # of days worked per week, prior to the leave request. | |
| 9b. | Average # of hours worked per week, prior to the leave request. | |

**9c. Days of the week the employee usually works**

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

**9d. Address where the employee performs the majority of their work**

Street:_____

City/St/Zip:)_____

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

**10.Employee's Job Title/Description of duties**

**11. Employment status for the employee requesting leave**

Date employed: _____ mm/dd/yyyy

In active employment: ☐ **Yes** ☐ **No**

Termination Date: _____ mm/dd/yyyy

**12. 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.*

Start date (mm/dd/yyyy) Through (mm/dd/yyyy)

Continuous Leave:

Intermittent Leave: Dates requested:

*Episodic time off*

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

*A consistent but reduced schedule for multiple weeks.*

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

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

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

Detail:

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

☐ **Yes** ☐ **No**

**14. 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/yy) | through (mm/dd/yy) |
|---|---|---|---|---|---|
| a. | Unemployment benefits | ☐ | ☐ | | - |
| b. | Workers' Compensation | ☐ | ☐ | | - |
| c. | PFML | ☐ | ☐ | | - |
| d. | Other (Sick/Vacation/PTO or other employer provided leave. Please specify.) | ☐ | ☐ | | - |

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

**15. Will the employee receive any wages or other benefits (see above) during any part of the requested leave period?**

☐ **Yes** ☐ **No**

↓

Provide exact dates and type of wages or benefits received on a separate sheet.

**16. Is the employee taking FMLA concurrently with this leave?**

☐ **Yes** ☐ **No**

**17. Employee & Employer Contributions** ShelterPoint will rely on and use the information you provide in response to these questions to (1) determine the amount of tax, if any, it is required to withhold from any claim payments and (2) determine the amount it is required to report on applicable tax forms, if any, that it has agreed to file.

**a.** Does the employee contribute to the cost of the MA Paid Medical leave (PML) coverage? ☐ **Yes** ☐ **No**

Answer I. below — Skip a.I and go to question **17.b**.

**I.** If yes, what percentage of the overall MA PML premium does the employee pay?
*If left blank, we will assume the employee contributes the maximum allowable.* _____**%**

**b.** Does the employee contribute to the cost of the MA Paid Family Leave (PFL) coverage? ☐ **Yes** ☐ **No**

Answer I. below — Skip b.I and go to question **18**.

**I.** If Yes, what percentage of the overall MA PFL premium does the employee pay?
*If left blank, we will assume the employee contributes the maximum allowable.* _____**%**

**18. ShelterPoint MA PFML Policy #**

### Declaration and Signature

***NOTICE*** Any person who knowingly 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.

I am the person authorized to sign as the employer of the employee requesting benefits under the Massachusetts Paid Family and Medical Leave Law. My signature affirms that to the best of my knowledge the information I have provided is true and accurate.

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

End of Part B.

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. 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.

## 1. Care Recipient Information

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

**Mailing address of Individual Receiving Care (Street Address (including apt/fl #), City, State, Zip)**

*Street address*

*City, State Zip*

**Care Recipient's Contact Phone #** **Care Recipient's Date of Birth** *(mm/dd/yyyy)*

( ) -

*area code*

## 2. Health Care Provider Information

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

**Mailing address of Health Care Provider (Street Address (including apt/fl #), City, State, Zip)**

*Street address*

*City, State Zip*

**Health Care Provider's Contact Phone #**

( ) -

*area code*

## 3. 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.

## 4. 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.

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

| **Signature of Care Recipient or Care Recipient's Legal Representative** | **Date signed** *(mm/dd/yyyy)* |
|---|---|
| | |

**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

# Request for Massachusetts Paid Family and Medical Leave (PFML)

# MEDICAL CERTIFICATION – SELF CARE FORM

## Employee Information (to be completed by the employee requesting medical 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)*

## MEDICAL CERTIFICATION (to be completed by the employee's treating health care provider)

**Instructions** Please print information legibly, and answer all questions fully and completely. When providing information surrounding the length/duration of a condition, or the frequency of treatment, be specific. Dates are intended to be best estimates based upon the medical facts for this patient, and in alignment with general guidelines. Do not use terms such as "unknown, lifetime, indeterminate", as this will delay the patient's claim process and the answers will be deemed incomplete. After completing this form, return it to the Patient.

**Definitions/Examples:**

**Serious Health Condition:** an illness, injury, impairment or physical or mental condition that involves:
(a) inpatient care in a hospital, hospice or residential medical facility; or
(b) continuing treatment by a health care provider.

**Inpatient care:** An overnight stay in a hospital, hospice, or residential medical care facility, including any period of incapacity, or any subsequent treatment in connection with such inpatient care.

**Continuing treatment by a health care provider:** Treatment for a condition that fits any of the following descriptions:

- Any incapacity to work for more than three consecutive full calendar days that also requires medical visits. The patient's first visit must be within seven days of the start of incapacity. Telehealth appointments are also included. These medical visits must meet one of the following two patterns:
  - Two or more visits within 30 days of a patient's incapacity to work (unless it is impossible to book two appointments in this timeframe).
  - One such visit—excluding a routine physical, eye or dental exam—plus a regimen of care or medication under the provider's supervision or prescription. E.g., outpatient surgery or strep throat.
- Any incapacity due to pregnancy or prenatal care.
- Any incapacity due to a chronic condition, which is a condition that:
  - Requires periodic medical visits,
  - Continues over an extended period of time, and
  - May cause episodic periods of incapacity that require leave. E.g., asthma or migraine headaches.
- Any incapacity due to a permanent or long-term condition that may not respond to treatment. E.g., Alzheimer's disease or terminal stages of cancer.
- Any absence to receive multiple treatments, plus any recovery time, for either of the following:
  - Restorative surgery after an accident or injury. E.g., joint replacements or reconstruction.
  - A condition that would lead to more than three consecutive days of incapacity if the patient did not receive treatment. E.g., chemotherapy treatments.

**Incapacity:** An inability to perform the functions of one's job owing to the serious health condition. For unemployed applicants, it means an inability to perform the functions of their most recent position or other suitable employment.

**1. Medical Information**

| | | |
|---|---|---|
| a. | Does the Patient have a **serious health condition**? See above for definitions | ☐ Yes ☐ No |
| b. | What was the first date on which the patient's serious health condition commenced? | |
| c. | What is the probable duration of the serious health condition? (eg: 3 months, 2 weeks) | |
| d. | Is the serious health condition job-related? | ☐ Yes ☐ No |

Medical Certification- Self Care form continues on the next page.

Employee Name: _____ Employee SSN:_____

Employee Address: _____

## MEDICAL CERTIFICATION (continued from previous page)

**1. Medical Information (Continued from previous page)**

| | | |
|---|---|---|
| e. | Is the serious health condition pregnancy related? (If yes, complete Pregnancy section) | ☐ Yes ☐ No |
| f. | Which of the following apply to the patient's serious health condition? Check all that apply | |

- ☐ Requires, or did require inpatient care
- ☐ Has incapacitated or will incapacitate the patient for more than 3 consecutive full calendar days
- ☐ Requires 2 or more medical visits within 30 days
- ☐ Requires 1 medical visit plus a regimen of care
- ☐ Is chronic, requires treatments at least 2x per year, and may require periodic absences
- ☐ Is long-term and requires ongoing medical supervision, with or without active treatment
- ☐ Requires multiple treatments and would lead to a period of incapacity without treatment

**2. Diagnosis/Analysis** Diagnosis code(s):

Signs & symptoms:

Objective findings:

**3. Treatment & Care** All questions must be completed. Missing or incomplete answers will delay processing of the claim. Do not list dates as "TBD", "Unknown" or "Lifetime".

| | | Date *(mm/dd/yyyy)* |
|---|---|---|
| a | First date of treatment (list the first date the patient received treatment or was seen by you for this serious health condition) | |
| b | Most recent date of treatment (the most recent date the patient was seen for this serious health condition) | |
| c | Date patient was unable to work because of this serious health condition (date patient deemed unable to perform their job duties due to their serious health condition) | |
| d | Date patient will be able to return to work (estimated date the patient may return to work. This is not the FMLA end date but the date the patient is medically capable of working). | |

**4. Pregnancy-related serious health condition**

| | | Date *(mm/dd/yyyy)* | |
|---|---|---|---|
| a | Estimated delivery date: | | |
| b | Actual delivery date: | | |
| c | Delivery type (Circle one if known) | Vaginal | C-Section |
| d | Antepartum complications, if any: | | |
| e | Postpartum complications, if any: | | |

*A standard postpartum recovery period is 6 weeks for normal delivery and 8 weeks for C-Section. Unless complications are present and noted in this certification to support extension of the recovery period, the estimated return to work date will be applied based on this 6 or 8 week standard.*

Medical Certification- Self Care form continues on next page.

Employee Name: _____ Employee SSN:_____

Employee Address: _____

## MEDICAL CERTIFICATION (continued from previous page)

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

| | | Start Date *(mm/dd/yyyy)* | End Date *(mm/dd/yyyy)* |
|---|---|---|---|
| a | ☐ Continuous leave<br>*Completely unable to work for consecutive, uninterrupted days.* | | |
| b | ☐ Reduced leave schedule<br>*A consistent but reduced schedule for multiple weeks.* | | |
| | Frequency of leave required (eg: 2 days per week, or 4 hours per day, or every Monday) | | |
| c | ☐ Intermittent leave<br>*Episodic time off at irregular intervals for flare-ups or unexpected aftercare.* | Start Date *(mm/dd/yyyy)* | End Date *(mm/dd/yyyy)* |
| | Frequency of leave required for flare-ups or treatments relating to this serious health condition (eg: 1 episode every 3 months lasting 1-2 days) | Freq. of Episode / # times | Per Week / Per Month / Per Year |
| | | Length of episode: | # Minutes / # Hours / # Full day(s) |

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

| | | | |
|---|---|---|---|
| First & Last Name: | | Professional Designation (Ex: MD, DO, PA, CNM) | |
| Phone #: | | License State**:** | |
| Fax #: | | License #: | |
| Mailing Address: (Practice name, Street address, City, St Zip) | | | |

### Certification and Signature

***NOTICE*** Any person who knowingly 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.

My signature attests 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, and that I am a health care provider authorized to certify their condition.

| **Health Care Provider's Signature** | **Date** (mm/dd/yyyy) |
|---|---|
| | |

End of Medical Certification- Self Care form.