Checklist for Requesting Oregon Paid Family and Medical Leave (PFML)

Before you apply for benefits:

☐ **Check Eligibility Requirements For Leave.**

☐ **Plan your leave.** Leave can be taken continuously, intermittently, or on a reduced leave schedule, in accordance with OR PFML. The minimum time increment is one (1) day.

☐ **Notify your OR employer** at least 30 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 the CLAIMANT STATEMENT in its entirety.**

Sign and date the form, retain a copy for your files and give the claim package to your employer so they can complete the employer statement.

☐ **Your OR Employer completes the EMPLOYER STATEMENT in full, makes a copy for their file and returns to you.**

☐ **Complete the certification for your leave type (options on page 2) and attach supporting documentation**.

Submit your fully completed claim package to ShelterPoint or your employer's current OR PFML carrier:

Completed claims for OR 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 Insurance, 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.**

A complete application for benefits must be submitted to us within 30 days prior to the 1st confirmed day of leave. 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 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 person who, with an intent to knowingly defraud or knowingly facilitate a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement of a material fact, may be guilty of insurance fraud.

Checklist for Requesting Oregon Paid Family and Medical Leave (OR PFML)

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 the OR - 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, organ or bone marrow donation)*

- ☐ 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 OR - MEDICAL CERTIFICATION – SELF CARE form.
- ☐ Your health care provider completes the remainder of the OR - 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 OR - MEDICAL CERTIFICATION – FAMILY CARE form, providing information on yourself and your qualifying family member requiring care.
- ☐ Your family member's health care provider completes the remainder of the OR - MEDICAL CERTIFICATION – FAMILY CARE form and returns the completed form to them/you.

☐ **Safe Leave**

- ☐ Complete the OR – SAFE LEAVE CERTIFICATION form.
- ☐ Attach proof documents supporting the leave (options listed on the form)

End of OR PFML Claim Checklist

SHELTERPOINT
ShelterPoint Insurance Company

Request for Oregon Paid Family and Medical Leave (PFML)

Claim Number:

CLAIMANT STATEMENT

This Application ("Claimant Statement") is completed by the individual that is requesting paid leave benefits (the "Claimant"). 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 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 TIN:

___ - ___ - ____

4. Claimant's Date of Birth:

__ / __ / ____

MONTH DAY YEAR

5. Claimant's Gender:

☐ Male
☐ Female
☐ Not Designated/Other

6. Claimant's Contact Phone Number:

(___) ___ - ____

area code

7. Claimant's Contact Email Address:

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 child due to domestic violence, harassment, sexual assault, or stalking

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	☐	Grandparent or Grandparent's Spouse or Domestic Partner
☐	Spouse	☐	Grandchild or Grandchild's Spouse or Domestic Partner
☐	Domestic Partner	☐	Sibling or Sibling's Spouse or Domestic Partner
☐	Parent	☐	Spouse's Parent or Domestic Partner
☐	Child	☐	Child's Spouse or Domestic Partner

☐ 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.*

☐ **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 (Minimum increment 1 day)

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

Date(s) Requested:

☐ **Reduced Leave Schedule:**

A consistent but reduced work schedule taken in one (1) day increments for multiple weeks.

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

Frequency of leave in one (1) day increments: (eg: 2 days per week, or every Monday)

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 within 24 hours of the start of leave, and written notice within 3 days after the leave begins.

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	☐	☐		
b.	Workers' Compensation	☐	☐		
c.	Oregon Family Leave Act (OFLA)	☐	☐		
d.	OR PFMLI/Paid Leave Oregon	☐	☐		

Form continues on next page

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

Claimant Address: _____

Employment Information

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

KEY TERMS:

Benefit year: period of 52 consecutive weeks beginning on the Sunday immediately preceding the day that OR PFML begins.

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

Wages: Includes but not limited to: commission or a guaranteed wage, compensatory pay, bonuses, vacation/PTO/sick/holiday pay, tips & gratuities, dismissal or separation allowances.

Wages does not include: expense reimbursement for meals/travel, pensions, jury pay, gifts other than tips/gratuities, benefits paid through a cafeteria plan.

Example: *Jada requests OR PFML for bonding leave with a leave start date of **9/20/2023**. Her benefit year will begin on 9/17/2023, which is the Sunday prior to the start of leave on 9/20/2023. Jada's base year for reporting wages is the **first (4)** of the **previous (5) completed quarters**. Based on her start date, the lookback quarters are 1. 4/1 – 6/30/22 2. 7/1 – 9/30/22 3. 10/1 – 12/31/22 4. 1/1 – 3/31/23 5. 4/1 – 6/30/23. The gross wages from these first 4 quarters (4/1/2022 – 3/31/2023) will be used to determine her average weekly wage. Jada's gross wages during that time period was $39,000 making her base weekly earnings $750. This amount will be used to calculate her weekly benefit rate under OR PFML.*

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

If you had more than one employer in the base year (the first four of the last five completed calendar quarters preceding the benefit year), name all employers. Wages is your sum total of gross (pre-tax) wages in the first 4 of the last 5 quarters prior to your application for leave, for that employer. Wages should only reflect wages earned in OR employment. Average hours and days worked per week is based off your Regular Work Schedule, averaged from the 12 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)	Days of the Week usually worked:	Gross ($) Wages in Base Year
			☐Mo ☐Tu ☐We ☐Th ☐Fr ☐ Sa ☐Su - - - - - - - - - - - - - - - - - - ☐ Schedule Varies	

Other OR Employer(s)

Business Name, Address/City/St/Zip, Tax ID #	Avg # hours/week (e.g. 40 hrs/wk)	Avg # days/week (e.g. 5 days/wk)	Days of the Week usually worked:	Gross ($) Wages in Base Year
			☐Mo ☐Tu ☐We ☐Th ☐Fr ☐ Sa ☐Su - - - - - - - - - - - - - - - - - - ☐ Schedule Varies	
Business Name, Address/City/St/Zip, Tax ID #	**Avg # hours/week** (e.g. 40 hrs/wk)	**Avg # days/week** (e.g. 5 days/wk)	**Days of the Week usually worked:**	**Gross ($) Wages in Base Year**
			☐Mo ☐Tu ☐We ☐Th ☐Fr ☐ Sa ☐Su - - - - - - - - - - - - - - - - - - ☐ Schedule Varies	

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

14. Consent to Obtain Wages From all OR Employers:

Only complete this question if you had more than one (1) OR employer during the base year.

If you have had more than one OR employer in the base year, do We have your consent to contact the Oregon Employment Department (OED) to obtain all wages reported in the base year, including from your other employer(s)?

☐ Yes, I consent. ☐ No, I do not consent.

Print Name:_____

Signature: _____

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 types of leave, will be provided to the employer.

15. 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 may be 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

Declaration and Signature:

WARNING: Any person who, with an intent to knowingly defraud or knowingly facilitate a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement of a material fact, may be guilty of insurance fraud. I further certify that if benefits are paid in excess of the amount to which I am entitled, I will return to the payor of such benefits, the amount that was overpaid, and I acknowledge that failure to do so may result in the accrual of interest and other penalties.
I am hereby making a request for benefits under Oregon Paid Family and Medical Leave Insurance. 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 OR PFML - Claimant Statement.

SHELTERPOINT
ShelterPoint Insurance Company

Request for Oregon Paid Family and Medical Leave (PFML)

Claim Number:

Claimant's Legal Name:		**Claimant's SSN:**	☐☐☐-☐☐-☐☐☐☐
Claimant's Mailing Address:			

Employer Statement (To be completed by the employer for the above named employee ("Claimant") requesting OR PFML)

Retain a copy of the completed form for your files, and return completed form to the claimant, as soon as possible. Claims filing is the responsibility of the claimant.

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

1. Business's Full Legal Name & Mailing Address:

Business name (including any DBA or Trade Name)

Street address

City, State Zip

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

☐☐ - ☐☐☐☐☐☐☐

3. Employer Contact Person (Name & Title) for this leave request:

4. Employer's Contact Phone #:

(☐☐☐) ☐☐☐ - ☐☐☐☐ Ext: _____

area code

5. Employer Contact Email Address:

6. Employee's Hire Date:

☐☐ / ☐☐ / ☐☐☐☐

month *day* *year*

7. Employee's Current Employment Status:

☐ Actively employed-not terminated

☐ Terminated from employment (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. Oregon 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 OR? ☐ Yes ☐ No (answer question 10c.)

c. Is the employee's service localized (performed entirely) within OR? ☐ Yes ☐ No (answer question 10d.)

d. If services are not localized, is the employee's base of operations in OR, and some of the work is performed in OR? ☐ Yes ☐ No (answer question 10e.)

e. If there is no base of operations, does the employee perform some of the services within OR and receive direction and control from OR ? ☐ Yes ☐ No (answer question 10f.)

f. If there is no place of direction and control, no localized services and no base of operations in OR, does the employee reside in OR? ☐ Yes ☐ No

Form continues on next page

Claimant's Legal Name:	Claimant's SSN: ☐☐☐ - ☐☐ - ☐☐☐☐
Claimant's Mailing Address:	

Employer Information - Continued from previous page

11. Employee's Job Title:

12. Employee's Normal Working Schedule & Hours Worked:

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

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

Average # of work days per work week: _____

b. Provide the scheduled work hours from the last 12 weeks the employee reported to work prior to the last day worked before leave

Week #	Scheduled Weekly Hours (e.g. 40 hours)
Week 1	
Week 2	
Week 3	
Week 4	
Week 5	
Week 6	
Week 7	
Week 8	
Week 9	
Week 10	
Week 11	
Week 12	
Average	

13. Provide the Employee's Wages During the Base Year:

"Wages" includes but is not limited to: commission or a guaranteed wage, compensatory pay, bonuses, vacation/PTO/sick/holiday pay, tips & gratuities, dismissal or separation allowances.

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

"Benefit Year" means the period of 52 consecutive weeks beginning on the Sunday immediately preceding the day that OR PFML begins

***Example:** Jada requests OR PFML for bonding leave with a leave start date of **9/20/2023**. Her benefit year will begin on 9/17/2023, which is the Sunday prior to the start of leave on 9/20/2023. Jada's base year for reporting wages is the **first (4)** of the **previous (5) completed quarters**. Based on her start date, the lookback quarters are 1. 4/1 – 6/30/22 2. 7/1 – 9/30/22 3. 10/1 – 12/31/22 4. 1/1 – 3/31/23 5. 4/1 – 6/30/23. The gross wages from these first 4 quarters (4/1/2022 – 3/31/2023) will be used to determine her average weekly wage. Jada's gross wages during that time period was $39,000 making her base weekly earnings $750. This amount will be used to calculate her weekly benefit rate under OR PFML.*

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

14. Will Leave be Utilized Continuously or Intermittently? Provide Details Below. *Any changes to your employee's leave plans and/or estimated dates, must be communicated/confirmed to Us as soon as possible.*

☐ **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. Minimum increment is (1) day.

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

Date(s) Requested:

☐ **Reduced Leave Schedule:**

A consistent but reduced work schedule taken in one (1) day increments for multiple weeks.

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

Frequency of Leave in one (1) day increments: *(e.g. 2 days per week or every Monday)*

Form continues on next page

Claimant's Legal Name:	Claimant's SSN: ☐☐☐ - ☐☐ - ☐☐☐☐
Claimant's Mailing Address:	

Employer Information - Continued from previous page

15. Notice to Employer

Foreseeable leave (*a qualifying event such as a planned medical procedure/treatment for the claimant or their qualified family member, or for the birth of/placement of a new child*) requires advance notice to the employer. Unforeseeable leave (*emergency basis or unexpected*) requires notice to the employer within 24 hours of the start of leave, and written notice within 3 days after the leave begins.

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

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

c. **Will employer waive the 30 day advance notice requirement for foreseeable leave?** ☐ **Yes** ☐ **No**

16. 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	☐	☐		-
b.	Workers' Compensation	☐	☐		-
c.	Oregon Family Leave Act (OFLA)	☐	☐		-
d.	OR PFMLI/Paid Leave Oregon	☐	☐		-

17. Employer - Provided Paid Leave During Leave Period:

Family and medical leave insurance benefits are in addition to any paid sick time under ORS 653.606, vacation leave or other paid leave earned by an employee. An employer may permit an employee to use paid sick time, vacation leave or any other paid leave earned by the employee in addition to receiving paid family and medical leave insurance benefits to replace an employee's wages.

a. Will the employee be using any employer-provided paid leave **during the leave period requested?**

☐ Yes (answer question b) ☐ No (go to question # 18)

b. Will the employee be receiving **wage replacement** (e.g. salary continuation) **during all or a portion of the leave period requested?**
☐ Yes – (answer question i and ii) ☐ No (go to question # 18)

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 OR PFML benefits? ☐ Yes ☐ No

18. Employee 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 OR Paid Medical leave (PFML) coverage?

☐ **Yes** — Answer I and II. below

☐ **No** — Skip a.I and II and go to question 19.

I. If yes, what percentage of the overall OR PFML premium does the employee pay towards the MEDICAL LEAVE portion of PFML? _____**%**

If left blank, we will assume the employee contributes the maximum allowable.

II. What percentage of the overall OR PFML premium does the employee pay towards the FAMILY LEAVE portion of PFML? _____**%**

If left blank, we will assume the employee contributes the maximum allowable.

Form continues on next page

Claimant's Legal Name:	Claimant's SSN: ☐☐☐ - ☐☐ - ☐☐☐☐
Claimant's Mailing Address:	

Employer Information - Continued from previous page

19. OR PFML Policy #:

Declaration and Signature

WARNING: Any person who, with an intent to knowingly defraud or knowingly facilitate a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement of a material fact, may be guilty of insurance fraud.

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

Signature	Date Signed
	☐☐ / ☐☐ / ☐☐☐☐ (month / day / year)

End of OR- PFML Employer Statement.

ShelterPoint Insurance Company
Administrative Office:
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 OR PFML is being requested to the paid family and medical leave ("OR PFML") insurance carrier listed below.

Carrier Name: SHELTERPOINT 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
ShelterPoint Insurance Company

Request for Oregon Paid Family and Medical Leave (PFML)

Claim Number:

OREGON MEDICAL LEAVE CERTIFICATION - FAMILY CARE

Family Care Leave allows an eligible 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"). 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 individual requesting leave to care for a family member with a serious health condition)

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: (9 digits)

☐☐☐ - ☐☐ - ☐☐☐☐

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 serious 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 (including apt/fl #), City, State, Zip):

Street address

City, State Zip

4. Family Member's Relationship to Claimant Requesting Leave:

☐ Spouse ☐ Parent or Spouse's Parent ☐ Child (of any age) or Child's Spouse ☐ Grandchild ☐ Grandparent or Spouse's Grandparent
☐ Sibling or Spouse's Sibling
☐ Individual related by blood or affinity whose close association the Claimant considers equal to that of family relationship

5. Provide Detail on the Type of Care the Family Member Will Need:

☐ Assistance with basic medical, hygienic, nutritional, or safety needs

☐ Transportation ☐ Physical care ☐ Psychological comfort

☐ Other: (please describe):

Form continues on next page

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

Patient Name: _____ Patient DOB: ☐☐/☐☐/☐☐☐☐

MEDICAL CERTIFICATION (Completed by family member'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 or their Family Member. Do not provide 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 Claimant's family members, 29 C.F.R. § 1635.3(b).

Definitions & Examples:

A **serious health condition** is an illness, injury, impairment, or physical or mental condition that meets one or more of the following criteria:

- Requires inpatient care in a medical care facility (i.e. hospital, hospice, or residential facility such as a nursing home, inpatient substance abuse treatment center)
- Poses an imminent danger of death or possibility of death in the near future (e.g. terminal prognoses)
- Requires constant or continuing care (including home care administered by a health care professional)
- Involves a period of incapacity (which may be periodic, permanent, or long term)
- Involves multiple treatments
- Involves a period of disability due to pregnancy, childbirth, miscarriage, or stillbirth, or a period of absence for prenatal care
- Involves any period of absence from work for organ, tissue, or bone marrow donation (including preoperative/diagnostic services, surgery, post-operative treatment and recovery)

Inpatient care: An overnight stay in a hospital, hospice, nursing home, 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 (inability) to perform at least one essential job function, or to attend school or perform regular daily activities for more than three consecutive full calendar days. The incapacity must involve one of the following:
  - Two or more treatments by a health care provider; or
  - One treatment plus a regimen of continuing care
    - (e.g. therapy) or prescription medication (e.g. an antibiotic) under the provider's supervision.
    - **NOTE:** Taking of over-the-counter medications (e.g. aspirin), or bed-rest, drinking fluids, exercise, and other similar activities that can be initiated without a visit to a health care provider is not considered sufficient to be considered a regimen of continuing treatment.
- Any incapacity due to pregnancy or prenatal care.
- Any incapacity due to a chronic serious health condition, which:
  - requires periodic medical visits
  - continues over an extended period of time, and
  - may cause episodic periods of incapacity that require leave (e.g., asthma, migraine headaches, diabetes, epilepsy).
- Any incapacity due to a permanent or long-term condition that may not respond to treatment (e.g. Alzheimer's disease, a severe stroke, or the terminal stages of a disease). The individual must be under the continuing care of a heath care provider but need not be receiving active treatment.
- 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 calendar days of incapacity if the patient did not receive treatment. E.g., cancer (chemotherapy or radiation treatments), severe arthritis (physical therapy), kidney disease (dialysis).

1. Medical Information:

a.	Does the Patient (f*amily member listed on page 1 of this form*) have a **serious health condition** that requires care from their family member ("Claimant")? See above for definitions	☐ Yes ☐ No
b.	What was the first date on which the patient's serious health condition commenced?	*(mm/dd/yyyy)*
c.	What is the probable duration of the serious health condition? *(e.g. 3 months, 2 weeks)*	
d.	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

☐ Requires 1 medical visit plus a regimen of care

☐ Is chronic, requires treatments, 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

☐ Is terminal

Form continues on next page

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

Patient Name: _____ Patient DOB: ☐☐/☐☐/☐☐☐☐

MEDICAL CERTIFICATION (Completed by Family Member's treating Health Care Provider)

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

Signs & symptoms:

Objective findings:

3. Leave Needed: Indicate whether your patient (f*amily member listed on page 1 of this form*) will require care by the Claimant listed above (the patient's family member) on a continuous or intermittent basis. If intermittent, provide detail of the frequency of leave needed, and approximate duration per episode. Check all that apply.

		Start Date *(mm/dd/yyyy)*	End Date/Thru *(mm/dd/yyyy)*			
a	☐ Continuous leave *Completely unable to work for consecutive, uninterrupted days.*					
b	☐ Intermittent leave/Reduced Leave *Intermittent leave is Leave in separate, non-consecutive time periods rather than a single span of time for a single qualifying reason. Episodic time off. Reduced leave is leave required to be taken in a consistent but reduced schedule for multiple weeks. Minimum time increment is **1 day**.*	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 (e.g. 1 episode every 3 months lasting 1-2 days)	Freq. of Episode	# times	Per Week	Per Month	Per Year
		Length of episode:	# Full day(s) *(minimum leave increment is 1 day)*			

4. 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.

Provider Type: ☐ **DC** ☐ **MD** ☐ **DO** ☐ **CNM** ☐ **DDS/DMD** ☐**OD** ☐**PA** ☐**PSY D** ☐**RN** ☐ **CSW** ☐**Spiritual provider** (e.g. Christian Science Practitioner)

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

Certification and Signature:

WARNING: *Any person who, with an intent to knowingly defraud or knowingly facilitate a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement of a material fact, may be guilty of insurance fraud.*

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 Signed** ☐☐ / ☐☐ / ☐☐☐☐ MONTH DAY YEAR

End of OR PFML - Medical Certification- Family Care form.

Direct Deposit Enrollment and Authorization Form for Oregon Paid Family and Medical Leave (OR 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 Insurance Company (the "Company") offers Direct Deposit Payments on Oregon 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 Insurance, 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

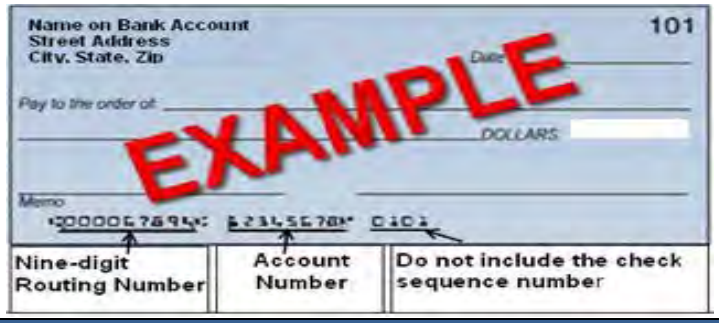
☐ Checking Account ☐ Savings Account

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 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)**