

Oregon Paid Family and Medical Leave (PFML)

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.

<u>Submit your fully completed claim package to ShelterPoint or your employer's</u> 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.



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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)



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 inco	0	mation may delay processi	ng.
Demo	ographic Information			
1. Clain	nant's Legal Name (First Name, Middle Initial, Last Name):	<u> </u>		
First na			ast Name	
2. Claim	nant's Mailing Address (Street Address (including apt/fl #)	, City, State, 2	<u>Zip):</u>	
Street a	ddress			
City, Sta	ate Zip			
3. Clain	nant's Social Security Number or TIN:	4. Claiman	t's Date of Birth:	5. Claimant's Gender:
		MONTH	/ DAY / YEAR	☐ Male☐ Female☐ Not Designated/Other
6. Clain	nant's Contact Phone Number:	7. Claiman	t's Contact Email Address:	
(area code			
Leave	Information			
8. Reas	on 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, h	narassment, se	xual assault, or stalking	
9. Fami	ly Member's Relationship* to the Claimant is:			
* "Relati	ionship" includes "biological, foster, adoptive, step, and in loco parenti	is relationships a	and the same relationships to the Cla	imant's spouse or domestic
,	if applicable. Self		Grandparent or Grandparent's	Spouse or Domestic
			Partner	
	Spouse		Grandchild or Grandchild's Sp	
	Domestic Partner		Sibling or Sibling's Spouse or	
	Parent		Spouse's Parent or Domestic	
	Child		Child's Spouse or Domestic Pa	
	Individual who has a <i>significant personal bond</i> that is or is <i>like</i> on the totality of the circumstances surrounding the relationsh			
	a. I hereby assert that a family-like relationship exists between	n	and	and the same family file has 1 and 2
	b. Describe how this relationship demonstrates a family relation	(your no	(name of perso	n you have a family-like bond with)
	,,	- 1		

Claimant Name:			Claimant SSN:		-	
Claimant Address:						
Leave Information (continued from	n previous p	page)				
10. Leave Pattern and Period(s) Requested	<u>:</u>					
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:		Leave Start r the first date you are req		Enter the la	Leave End Date st date you are requesting	continuous
continuous uninterrupted period of leave for a single qualifying reason.	•	leave from wo	rk.		leave through.	
	month	/	year	/ month	day /	year
☐ Intermittent Leave:		Leave Start	Date	Date(s) R	equested:	
Leave in separate, non-consecutive time perior rather than a single span of time for a single qualifying		Enter the first date you as INTERMITTENT leave	re requesting			
reason; episodic time off (Minimum increment 1 day		/				
	mont	h day	year			
☐ Reduced Leave Schedule:		Leave Start		Frequency of	leave in one (1) d	<u>ay</u>
A consistent but reduced work schedule taken in o	ne Ente	r the first date you are req LEAVE from wo	uesting REDUCED ork.	increments: (e Monday)	eg: 2 days per week	, or every
(1) day increments for multiple weeks.	mon	//	L L L	,,		
	moni	th day	year			
11. Notice to Employer: Foreseeable leave (a qualifying event such as of/placement of a new child) requires advance your employer within 24 hours of the start of leaves.	notice to your e	employer. Unfore	seeable leave (<i>em</i> e	ergency basis o		
a. Was 30 day's advanced notice provided	to your employ	er for this leave	? □ Yes □ N	lo		
b. Date notice was provided to employer:	month da	y year]			
c. If 30 day's advance notice was not provide	ded, explain wh	ny:				
						_
12. Other Types of Leave:						<u> </u>
Provide detail on other types of benefits/leave requested leave period covered by this claim	taken or reques	itea in the precea	ing 52 weeks, and	wnether it will e	xtend through the	current
Benefit Type	received	claimed	from (mm/dd/yy		through (mm/dd/yyyy)	
a. Unemployment benefits				-		
b. Workers' Compensation				-		
c. Oregon Family Leave Act (OFLA)				-		
d. OR PFMLI/Paid Leave Oregon						
Ğ						

Claimant Name:		Claima	nt SSN:				
Claimant Address:							
Employment Information							
Employment Information	mana This is farme	-4::iii biii	and with the same and a same Daniel	a de de completor de la comple			
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 com	pleted calendar qu	arters preceding t	he benefit year				
Wages: Includes but not limited to: commis & gratuities, dismissal or separation allowa		ed wage, compens	satory pay, bonuses, vacation/F	PTO/sick/holiday pay, tips			
Wages does not include: expense reimbu through a cafeteria plan.	rsement for meals/	travel, pensions, j	ury pay, gifts other than tips/gra	atuities, benefits paid			
Example: Jada requests OR PFML for bonding leave with a lear 9/20/2023. Jada's base year for reporting wages is the first (4) of the 9/30/22 3. 10/1 – 12/31/22 4. 1/1 – 3/31/23 5. 4/1 – 6/30/23. The grada's gross wages during that time period was \$39,000 making here.	ne previous (5) comple oss wages from these fir or base weekly earnings	ted quarters . Based or rst 4 quarters (4/1/2022	n her start date, the lookback quarters a – 3/31/2023) will be used to determine	re 1. 4/1 – 6/30/22 2. 7/1 – her average weekly wage.			
13. Give the Name and Details of Your Recent En If you had more than one employer in the base year all employers. Wages is your sum total of gross (pre employer. Wages should only reflect wages earned a Schedule, averaged from the 12 weeks prior to your	r (the first four of th -tax) wages in the t in OR employment.	first 4 of the last 5 . Average hours al	quarters prior to your application	on for leave, for that			
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)			Octroduc 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			
	(13 1 11)	(13 11)	□Mo □Tu □We □Th □Fr				
			□ Sa □Su				
	Ave # havealusels	Ave # days/week	☐ Schedule Varies Days of the Week usually	Gross (\$) Wages in Base			
Business Name, Address/City/St/Zip, Tax ID #	Avg # hours/week (e.g. 40 hrs/wk)	Avg # days/week (e.g. 5 days/wk)	worked:	Year			
			□Mo □Tu □We □Th □Fr				
			□ Sa □Su				
			☐ Schedule Varies				
If more than 3 recent OR Employers, please include	details on a separa	te sheet	□ Scriedule varies				
14. Consent to Obtain Wages From all OR Emplo	<u> </u>	410 077001.					
Only complete this question if you had more than on	e (1) OR employer	during the base y	ear.				
If you have had more than one OR employer in Department (OED) to obtain all wages reported				on Employment			
☐ Yes, I consent. ☐ No, I do not consent.							
Drint Name							
Print Name:							
0:							
Signature:							
Signature:							
Signature:							
Signature:							

Claimant Name:	Claimant SSN:
Claimant Address:	
Benefit Payment Preferences	
Disclosure Statement: Information regarding PFML benefits re provided to the employer.	ceived by the employee, such as payments received and types of leave, will be
benefit recipient. If your claim does not qualify for ACH/direct of	ayments. Certain options may not be available depending on the leave pattern or deposit, your benefit payments will automatically be issued via paper check. A eposit and proof of account information may be required (e.g. a copy of a voided anking institution verifying account details).
☐ Paper Check ☐ Direct Deposit	
a false or deceptive statement of a material fact, may be guilty of insur- entitled, I will return to the payor of such benefits, the amount that was other penalties.	nowingly facilitate a fraud against an insurer, submits an application or files a claim containing rance fraud. I further certify that if benefits are paid in excess of the amount to which I am is overpaid, and I acknowledge that failure to do so may result in the accrual of interest and and Medical Leave Insurance. My signature affirms that the information I am providing is true
Signature	Date Signed /

End of OR PFML - Claimant Statement.



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) 2. Business's Federal Employer Identification Number (FEIN): 3. Employer Contact Person (Name & Title) for this leave request: 4. Employer's Contact Phone #: 5. Employer Contact Email Address: 6. Employee's Hire Date: 7. Employee's Current Employment Status: ☐ Actively employed-not terminated ☐ Terminated from employment (provide date below) **Date Terminated** 8. Last Day Worked Before Leave: 9. Has the Employee Returned to Work? ☐ Yes ☐ No Return to work date: □ Actual □ Estimated 10. Oregon Employment Verification: Are the employee's earnings reported at year end on IRS form W-2? ☐ Yes ☐ No (answer question 10b.) Is the employee subject to Unemployment Insurance obligations in OR? \Box Yes \Box No (answer question 10c.) b. Is the employee's service localized (performed entirely) within OR? ☐ Yes ☐ No (answer question 10d.) c. 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.) 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.) 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

Claimant's Legal Name	e :			Claimant's SSN:		
Claimant's Mailing Add	dress:					
Employer Informatio	n - Continued from p	revious	page			
11. Employee's Job Title						
12. Employee's Normal V	Vorking Schedule &			ee's Wages During the		
Hours Worked:					on or a guaranteed wage, holiday pay, tips & gratuities,	
a. Select the days of the week the employee usually works and list the average number of work days per			l or separation a		nonday pay, upo a gratatico,	
works and list the average week.	"Doos	" ' ' + l	finat form of the leat f	ivo completed colondor		
					ive completed calendar y of the individual's benefit	
☐ Mon ☐ Tue ☐ Wed ☐	Thur ☐ Fri ☐ Sat ☐ Sun	year.	- manual and a p		,	
Average # of work days	oer work week:	"Donofit	Voor" moone t	he period of FO cope	autiva waaka baginning an	tho
b. Provide the scheduled v	vork hours from the last			receding the day that	ecutive weeks beginning on OR PFML begins	lile
12 weeks the employee re	,	, , , , , , , , , , , , , , , , , , ,	3 · · · 3			
last day worked before lea	ve Scheduled Weekly Hours				a leave start date of 9/20/2023 . Her ber of leave on 9/20/2023. Jada's base yea	
	(e.g. 40 hours)	reporting wa	ages is the first (4) of	f the previous (5) completed	quarters. Based on her start date, the	
Week 1		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				
Week 2		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.				
Week 3			Base year	Quarter Ending	Wages]
Week 4			wages	Date	in ages	
Week 5		_		(mm/yyyy)	(\$)	
Week 6			Quarter 1			
		I	—			
Week 7			·			_
Week 7 Week 8		rear J	Quarter 2			
		ase year	Quarter 2			
Week 8		base year	·			
Week 8 Week 9		base year	Quarter 2			-
Week 8 Week 9 Week 10		base year	Quarter 2 Quarter 3 Quarter 4			
Week 8 Week 9 Week 10 Week 11		base year	Quarter 2 Quarter 3			
Week 8 Week 9 Week 10 Week 11 Week 12 Average	Continuously or Intermit		Quarter 2 Quarter 3 Quarter 4 Quarter 5 (most recent)	elow. Any changes to v	our employee's leave plans ar	nd/or
Week 8 Week 9 Week 10 Week 11 Week 12 Average	Continuously or Intermite	ently? Pro	Quarter 2 Quarter 3 Quarter 4 Quarter 5 (most recent)	elow. Any changes to y	our employee's leave plans ar	nd/or
Week 8 Week 9 Week 10 Week 11 Week 12 Average		ently? Pro Us as soo	Quarter 2 Quarter 3 Quarter 4 Quarter 5 (most recent) Divide Details Bern as possible. Leave Start Dat	<u> </u>	Leave End Date	
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Claim	ant's Legal Name:			Claimant's SSN	:	-	-	
Claim	ant's Mailing Address:							
Empl	oyer Information - Continued	from previo	us page					
	tice to Employer	•						
	eeable leave (a qualifying event such as							
	th of/placement of a new child) requires es notice to the employer within 24 hour							ectea)
				·		J		
a. Was	s 30 day's advanced notice provided	to you for this	leave?	□ No				
b. Dat e	e notice was provided to employer:	month d	lay / year					
o Will	employer waive the 30 day advance	notico roquiro	mont for foresonah	lo logyo2	□ No	•		
C. WIII	employer waive the 30 day advance	notice require	ment for <u>foreseeab</u>	ie leave? 🗆 1 es		,		
	ther Types of Leave: Provide detail on I through the current requested leave pe	eriod covered by	y this claim		eceding			ether it will
	Benefit Type	received	claimed	from (mm/dd/yyyy)		throug (mm/dd/y		
a.	Unemployment benefits				[
b.	Workers' Compensation				7 - [7
C.	Oregon Family Leave Act (OFLA)				- - [
					 			_ ¬
d.	OR PFMLI/Paid Leave Oregon ployer - Provided Paid Leave During	L cave Period			-			
Family earned	and medical leave insurance benefits a d by an employee. An employer may pe yee in addition to receiving paid family a	are in addition to rmit an employe	o any paid sick time to any paid sick ti	me, vacation leave or	any oth	ner paid leav		
a. Will	the employee be using any employer-p	rovided paid le	ave during the leav	e period requested?				
□ Ye	es (answer question b) No (go to question	# 18)						
	the employee be receiving wage replaces — (answer question i and ii) \square No (go to question)		alary continuation) du	uring all or a portion	of the	leave perio	d requ	ested?
	i. provide detail on type of wage repl	acement and t	he date(s) it will be p	aid for:				
	ii. are you requesting reimbursement	* for advance p	ayment of OR PFML	benefits? \square Yes	□ No			
Shelter	nployee Contributions: Point will rely on and use the information you by claim payments and (2) determine the amo	u provide in respo ount it is required	nse to these questions to report on applicable	to (1) determine the amo	ount of ta	ax, if any, it is ed to file.	required	d to withhold
						Yes		No
ā	a. Does the employee contribute to the	e cost of OR Pa	aid Medical leave (PF	FML) coverage?		and II. below		and II and go
							to quest	ion 19.
	I. If yes, what percentage of	the overall OR	PFML premium does	s the employee				
	pay towards the MEDICAL	LEAVE portion	of PFML?				_%	
	If left blank, we will assume the employe			mplayaa nay				
	II. What percentage of the over towards the FAMILY LEAV	E portion of PF	ML?	приуее рау				
	If left blank, we will assume the employe	e contributes the	maximum allowable.				_%	

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 ficontaining a false or deceptive statement of a material fact, may be guilty of insurance from	• ,,,
I am the person authorized to sign as the employer of the employee requesting benefits affirms that to the best of my knowledge the information I have provided is true, accurate	, , ,
Signature	Date Signed
	month day year
	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 2. Mailing Address of Individual Receiving Care (Street Address (including apt/fil #), City, State, Zip): Street address				
City, State Zip				
3. Care Recipient's Contact Phone #: 4. Care Recipient's Date of Birth:				
(area code) 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	ļ			
7. Health Care Provider's Contact Phone #:				
(area code - 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;	ļ			
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	ent's Legal Representative:	Date Signed:						
		MONTH DAY YEAR						
If signed by Care Recipient's Legal Repres	entative, complete the following:							
Printed Name of Care Recipient's Legal Rep	presentative:							
Relationship of Care Recipient to the Legal	Representative:							
Please Check which of the following provide	s authority to serve as a Legal representati	ve:						
Parental right;	Power of attorney (attach copy)							
Health care proxy (attach copy)	Court order (attach copy)							

End of HIPAA Authorization



Request for Oregon Paid Family and Medical Leave (PFML)

Claim Number:

OREGON MEDICAL LEAVE CERTIFICATION - SELF CARE

Medical Leave – Self Care allows an eligible individual to take leave from employment to attend to their own serious health condition. An individual may not exceed 12 weeks of paid leave in a benefit year, and up to 2 additional weeks of leave for limitations related to pregnancy, childbirth or related medical condition, for a total of 14 weeks. 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.

MEDICAL CERTIFICATION (to be completed by the Claimant'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. 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
 - $\circ\quad$ 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).

Clain	nant Addre	ss:			
MEDIO	CAL CER	TIFICATION (to be completed by the C	Claima	nt's treating health care provider)	
1. Medi	cal Informa	ation:			
a.	Does the	Patient have a serious health condition? See p	page 1 fo	r definitions	☐ Yes ☐ No
b.	What was	s the first date on which the patient's serious heal	th condit	ion commenced?	(mm/dd/yyyy)
C.	What is tl	ne probable duration of the serious health condition	on? (eg:	3 months, 2 weeks)	
d.	Is the ser	ious health condition job-related?			☐ Yes ☐ No
e.		ious health condition pregnancy related? (If yes, o			☐ Yes ☐ No
f.		ious health condition related to organ, tissue, or b			☐ Yes ☐ No
g Which of the following apply to the patient's serious health condition? Check all that apply					
[☐ Require	s, or did require inpatient care		Is chronic, requires treatments, and may require absences	e periodic
[apacitated or will incapacitate the patient for more than a tive full calendar days	3 🗆	Is long-term and requires ongoing medical super without active treatment	
[Require	s 2 or more medical visits		Requires multiple treatments and would lead to incapacity without treatment	a period of
[Require	s 1 medical visit plus a regimen of care		Is terminal	
	nosis/Anal		Diag	nosis code(s): 	
Signs &	symptoms				
Objectiv	e findings:				
		re: All questions must be completed. Missing or i	ncomple	te answers will delay processing of the	
ciaim. L	o not list c	lates as "TBD", "Unknown" or "Lifetime".			Date (mm/dd/yyyy)
а		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 p	oatient was s	een for this serious health condition)	
С		Date patient was unable to work because of this perform their job duties due to their serious health condition)	serious	health condition (date patient deemed unable to	
d		Date patient will be able to return to work (estimate date the patient is medically capable of working).	d date the pa	tient may return to work. This is not the FMLA end date but the	
4. Preg	nancy-rela	ted Serious Health Condition:			
	Cating at a d	deli con dete		Date (mm/dd/yyyy)	
a		delivery date:			
b		very date:		□Vaginal □C Section	
C		rpe (select one if known) m complications, if any:		□Vaginal □C-Section	
d	-	n complications, if any:			
е					
f	Does the plactation?	patient have any limitations related to pregnancy, ☐Yes ☐No	childbirtl	n, or related medical condition, including but	not limited to

Claimant Name: _____ Claimant SSN:

Clain	Claimant Name: Claimant SSN:								
Clain	nant Address:								
MEDIO	CAL CERTIFICATION	N (continued from pre	vious pag	e)					
require		cate whether your patient wi ermittent basis. If intermitten							
				rt Date (dd/yyyy)	l .	nd Date m/dd/yyyy)			
а	☐ Continuous Leave Completely unable to work for c	onsecutive, uninterrupted days.							
b	periods rather than a single spreason. Episodic time off. Red	separate, non-consecutive time oan of time for a single qualifying uced leave is leave required to be ced schedule for multiple weeks.	Start Date	(mm/dd/yyyy)	End Date	e (mm/dd/yyyy	Σ		
J	Frequency of leave requ		Freq. of Episode	# times	Per Week	Per Month	<u>Per</u>	Year	
	treatments relating to this serious health condition (e.g. 1 episode every 3 months lasting 1-2 days)		Length of episode:		# Full day(s) (minimum leave increment is 1 day)				
complete	th Care Provider Informated form to the patient.						-		
Provide	r Type: □ DC □ MD □	DO 🗆 CNM 🗆 DDS/DMD 🗆	□OD □PA □	PSY D □RN [□ CSW □Spi	iritual provide) (e.g. Christian	n Science Pract	itioner)
Provide	r's First & Last Name:					al Designation O, PA, CNM)	ı		
Phone #	‡ :				License Sta	ate:			
Fax #:					License #:				
•	Address: (Practice name, Idress, City, State, Zip)								
Certific	cation and Signature								
_		n an intent to knowingly defra deceptive statement of a ma		~ .	•		ıbmits an	application	on or
		mation provided in this form in this form in this form in the lam a health				-	l answere	d the que	estions
Health	Care Provider's Signatu	re			Date	Signed			
							\neg / \vdash		

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



Direct Deposit Enrollment and Authorization Form for Oregon Paid Family and Medical Leave (OR PFML)

2. Social Security Number or I-TIN

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

REQUIRED INFORMATION (please print all information CLEARLY)

> Email to: claimforms@shelterpoint.com

1. Claimant Name (First name, Last name)

- 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.

3. ShelterPoint Claim Number(s)			
4. Account Type ☐ Checking Account ☐ Savings Account	Name on Bank Acc Street Address City, State, Zip		101
5. Banking Information	Pay to the order of:		DLE
Bank Name:	_	1 7/1	DOLLARS
Bank Routing Number (ABA#):	Pay to the order of		
Bank Account Number:	Nine-digit Routing Number	Account Number	Do not include the check sequence number
	Routing Number	Iddiliber	sequence 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 (ı	mm/dd/yyyy)	
	1		