

**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](mailto:claimforms@shelterpoint.com)

**Fax:** 516-504-6414

**Mail:** ShelterPoint Insurance, 1225 Franklin Ave-Ste 475, Garden City NY 11530

Web address: [www.shelterpoint.com](http://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 1<sup>st</sup> 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)



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 <small>(mm/dd/yyyy)</small>	through <small>(mm/dd/yyyy)</small>
a. Unemployment benefits	<input type="checkbox"/>	<input type="checkbox"/>	[ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]	[ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]
b. Workers' Compensation	<input type="checkbox"/>	<input type="checkbox"/>	[ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]	[ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]
c. Oregon Family Leave Act (OFLA)	<input type="checkbox"/>	<input type="checkbox"/>	[ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]	[ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]
d. OR PFMLI/Paid Leave Oregon	<input type="checkbox"/>	<input type="checkbox"/>	[ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]	[ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]

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 <small>(e.g. 40 hrs/wk)</small>	Avg # days/week <small>(e.g. 5 days/wk)</small>	Days of the Week usually worked:	Gross (\$) Wages in Base Year
			<input type="checkbox"/> Mo <input type="checkbox"/> Tu <input type="checkbox"/> We <input type="checkbox"/> Th <input type="checkbox"/> Fr <input type="checkbox"/> Sa <input type="checkbox"/> Su ----- <input type="checkbox"/> Schedule Varies	

**Other OR Employer(s)**

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



<b>Claimant's Legal Name:</b>	<b>Claimant's SSN:</b> <input type="text"/> - <input type="text"/> - <input type="text"/>
<b>Claimant's Mailing Address:</b>	

**Employer Information - Continued from previous page**
**11. Employee's Job Title:**

<b>12. Employee's Normal Working Schedule &amp; Hours Worked:</b>  <b>a.</b> Select the days of the week the employee usually works and list the average number of work days per week.  <input type="checkbox"/> Mon <input type="checkbox"/> Tue <input type="checkbox"/> Wed <input type="checkbox"/> Thur <input type="checkbox"/> Fri <input type="checkbox"/> Sat <input type="checkbox"/> Sun  Average # of work days per work week: _____  <b>b.</b> Provide the scheduled work hours from the last 12 weeks the employee reported to work prior to the last day worked before leave <table border="1" style="width:100%; border-collapse: collapse; margin-top: 10px;"> <thead> <tr> <th style="width:15%;">Week #</th> <th style="width:85%;">Scheduled Weekly Hours (e.g. 40 hours)</th> </tr> </thead> <tbody> <tr><td>Week 1</td><td></td></tr> <tr><td>Week 2</td><td></td></tr> <tr><td>Week 3</td><td></td></tr> <tr><td>Week 4</td><td></td></tr> <tr><td>Week 5</td><td></td></tr> <tr><td>Week 6</td><td></td></tr> <tr><td>Week 7</td><td></td></tr> <tr><td>Week 8</td><td></td></tr> <tr><td>Week 9</td><td></td></tr> <tr><td>Week 10</td><td></td></tr> <tr><td>Week 11</td><td></td></tr> <tr><td>Week 12</td><td></td></tr> <tr> <td style="text-align: right;"><b>Average</b></td> <td></td> </tr> </tbody> </table>	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		<b>Average</b>		<b>13. Provide the Employee's Wages During the Base Year:</b> <i>"Wages" includes but is not limited to: commission or a guaranteed wage, compensatory pay, bonuses, vacation/PTO/sick/holiday pay, tips &amp; gratuities, dismissal or separation allowances.</i>  <i>"Base year" means the first four of the last five <b>completed calendar quarters</b> immediately preceding the first day of the individual's benefit year.</i>  <i>"Benefit Year" means the period of 52 consecutive weeks beginning on the Sunday immediately preceding the day that OR PFML begins</i>  <b>Example:</b> Jada requests OR PFML for bonding leave with a leave start date of <b>9/20/2023</b> . 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 <b>first (4)</b> of the <b>previous (5) completed quarters</b> . 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.  <table border="1" style="width:100%; border-collapse: collapse; margin-top: 10px;"> <thead> <tr> <th style="width:10%;"></th> <th style="width:35%;">Base year wages</th> <th style="width:20%;">Quarter Ending Date (mm/yyyy)</th> <th style="width:35%;">Wages (\$)</th> </tr> </thead> <tbody> <tr> <td rowspan="5" style="text-align: center; vertical-align: middle;">base year</td> <td>Quarter 1</td> <td></td> <td></td> </tr> <tr> <td>Quarter 2</td> <td></td> <td></td> </tr> <tr> <td>Quarter 3</td> <td></td> <td></td> </tr> <tr> <td>Quarter 4</td> <td></td> <td></td> </tr> <tr> <td>Quarter 5 (most recent)</td> <td></td> <td></td> </tr> </tbody> </table>		Base year wages	Quarter Ending Date (mm/yyyy)	Wages (\$)	base year	Quarter 1			Quarter 2			Quarter 3			Quarter 4			Quarter 5 (most recent)		
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**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.

<input type="checkbox"/> <b>Continuous Leave:</b>  <i>continuous uninterrupted period of leave for a single qualifying reason.</i>	<table style="width:100%; border-collapse: collapse;"> <tr> <td style="width:50%; text-align: center; padding: 5px;"> <u>Leave Start Date</u>  <small>Enter the first date the EE is requesting continuous leave from work.</small>  <input type="text"/> / <input type="text"/> / <input type="text"/> <div style="display: flex; justify-content: space-around; font-size: 8px; margin-top: 2px;"> <span>month</span> <span>day</span> <span>year</span> </div> </td> <td style="width:50%; text-align: center; padding: 5px;"> <u>Leave End Date</u>  <small>Enter the last date the EE is requesting continuous leave through.</small>  <input type="text"/> / <input type="text"/> / <input type="text"/> - <input type="text"/> / <input type="text"/> / <input type="text"/> <div style="display: flex; justify-content: space-around; font-size: 8px; margin-top: 2px;"> <span>month</span> <span>day</span> <span>year</span> <span style="margin: 0 10px;">-</span> <span>month</span> <span>day</span> <span>year</span> </div> </td> </tr> </table>	<u>Leave Start Date</u> <small>Enter the first date the EE is requesting continuous leave from work.</small> <input type="text"/> / <input type="text"/> / <input type="text"/> <div style="display: flex; justify-content: space-around; font-size: 8px; margin-top: 2px;"> <span>month</span> <span>day</span> <span>year</span> </div>	<u>Leave End Date</u> <small>Enter the last date the EE is requesting continuous leave through.</small> <input type="text"/> / <input type="text"/> / <input type="text"/> - <input type="text"/> / <input type="text"/> / <input type="text"/> <div style="display: flex; justify-content: space-around; font-size: 8px; margin-top: 2px;"> <span>month</span> <span>day</span> <span>year</span> <span style="margin: 0 10px;">-</span> <span>month</span> <span>day</span> <span>year</span> </div>
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Form continues on next page

<b>Claimant's Legal Name:</b>	<b>Claimant's SSN:</b> <input style="width:20px; height:20px;" type="text"/> - <input style="width:20px; height:20px;" type="text"/> - <input style="width:20px; height:20px;" type="text"/>
<b>Claimant's Mailing Address:</b>	

**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 <small>(mm/dd/yyyy)</small>	-	through <small>(mm/dd/yyyy)</small>
a. Unemployment benefits	<input type="checkbox"/>	<input type="checkbox"/>	<input style="width:100%; height:20px;" type="text"/>	-	<input style="width:100%; height:20px;" type="text"/>
b. Workers' Compensation	<input type="checkbox"/>	<input type="checkbox"/>	<input style="width:100%; height:20px;" type="text"/>	-	<input style="width:100%; height:20px;" type="text"/>
c. Oregon Family Leave Act (OFLA)	<input type="checkbox"/>	<input type="checkbox"/>	<input style="width:100%; height:20px;" type="text"/>	-	<input style="width:100%; height:20px;" type="text"/>
d. OR PFMLI/Paid Leave Oregon	<input type="checkbox"/>	<input type="checkbox"/>	<input style="width:100%; height:20px;" type="text"/>	-	<input style="width:100%; height:20px;" type="text"/>

**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       No
- Answer I and II. below      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

<b>Claimant's Legal Name:</b>	<b>Claimant's SSN:</b> <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
<b>Claimant's Mailing Address:</b>	

**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.*

<b>Signature</b>	<b>Date Signed</b> <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <small>month                      day                      year</small>
------------------	--

*End of OR- PFML Employer Statement.*

## 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)**

<i>First name</i>	<i>Middle initial</i>	<i>Last name</i>
-------------------	-----------------------	------------------

**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 #:**

**4. Care Recipient’s Date of Birth:**

( <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> ) <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> - <input style="width: 20px; height: 20px;" type="text"/> <p style="text-align: center; font-size: small; margin-top: 5px;"><i>area code</i></p>	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="border: 1px solid black; width: 20px; height: 20px; text-align: center;"> </td> <td style="border: 1px solid black; width: 20px; height: 20px; text-align: center;"> </td> <td style="border: 1px solid black; width: 20px; height: 20px; text-align: center;"> </td> <td style="border: 1px solid black; width: 20px; height: 20px; text-align: center;"> </td> <td style="border: 1px solid black; width: 20px; height: 20px; text-align: center;"> </td> <td style="border: 1px solid black; width: 20px; height: 20px; text-align: center;"> </td> <td style="border: 1px solid black; width: 20px; height: 20px; text-align: center;"> </td> <td style="border: 1px solid black; width: 20px; height: 20px; text-align: center;"> </td> <td style="border: 1px solid black; width: 20px; height: 20px; text-align: center;"> </td> <td style="border: 1px solid black; width: 20px; height: 20px; text-align: center;"> </td> </tr> <tr> <td style="text-align: center; font-size: x-small;">MONTH</td> <td colspan="2"></td> <td style="text-align: center; font-size: x-small;">DAY</td> <td colspan="2"></td> <td style="text-align: center; font-size: x-small;">YEAR</td> <td colspan="3"></td> </tr> </table>											MONTH			DAY			YEAR			
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:

- |  |   |
|--|---|
| <input type="checkbox"/> HIV/AIDS related information; | <input type="checkbox"/> Mental health information; |
| <input type="checkbox"/> Substance Abuse information;  | <input type="checkbox"/> Psychotherapy notes        |

*HIPAA Authorization continues on the next 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:

<input type="text"/>	/	<input type="text"/>	/	<input type="text"/>	<input type="text"/>	<input type="text"/>
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:

- |  |  |
|--|--|
| <input type="checkbox"/> Parental right;                 | <input type="checkbox"/> Power of attorney (attach copy) |
| <input type="checkbox"/> Health care proxy (attach copy) | <input type="checkbox"/> Court order (attach copy)       |

End of HIPAA Authorization

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.

### Claimant Information (to be completed by the Claimant requesting medical leave)

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

First name \_\_\_\_\_ Middle initial \_\_\_\_\_ Last name \_\_\_\_\_

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

Street address \_\_\_\_\_

City, State Zip \_\_\_\_\_

**3. Claimant's Social Security Number or TIN:**

			-					
--	--	--	---	--	--	--	--	--

**4. Claimant's Date of Birth:**

		/			/				
MONTH			DAY			YEAR			

**5. Claimant's Gender:**

- Male
- Female
- Not Designated/Other

### 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
  - 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 health 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).

Form continues on next page

Claimant Name: \_\_\_\_\_ Claimant SSN:    -   -

Claimant Address: \_\_\_\_\_

**MEDICAL CERTIFICATION (to be completed by the Claimant's treating health care provider)**

**1. Medical Information:**

a.	Does the Patient have a <b>serious health condition</b> ? See <b>page 1</b> for definitions	<input type="checkbox"/> Yes <input type="checkbox"/> 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? (eg: 3 months, 2 weeks)	
d.	Is the serious health condition job-related?	<input type="checkbox"/> Yes <input type="checkbox"/> No
e.	Is the serious health condition pregnancy related? (If yes, complete Pregnancy section)	<input type="checkbox"/> Yes <input type="checkbox"/> No
f.	Is the serious health condition related to organ, tissue, or bone marrow donation?	<input type="checkbox"/> Yes <input type="checkbox"/> No
g.	Which of the following apply to the patient's serious health condition? Check all that apply	

- |  |  |
|--|--|
| <input type="checkbox"/> Requires, or did require <b>inpatient care</b>  | <input type="checkbox"/> Is chronic, requires treatments, and may require periodic absences                      |
| <input type="checkbox"/> Has incapacitated or will incapacitate the patient for more than 3 consecutive full calendar days | <input type="checkbox"/> Is long-term and requires ongoing medical supervision, with or without active treatment |
| <input type="checkbox"/> Requires 2 or more medical visits   | <input type="checkbox"/> Requires multiple treatments and would lead to a period of incapacity without treatment |
| <input type="checkbox"/> Requires 1 medical visit plus a regimen of care   | <input type="checkbox"/> Is terminal   |

**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:**

a.	Estimated delivery date:	Date (mm/dd/yyyy)
b.	Actual delivery date:	
c.	Delivery type (select one if known)	<input type="checkbox"/> Vaginal <input type="checkbox"/> C-Section
d.	Antepartum complications, if any:	
e.	Postpartum complications, if any:	
f.	Does the patient have any limitations related to pregnancy, childbirth, or related medical condition, including but not limited to lactation? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Form continues on next page

Claimant Name: \_\_\_\_\_ Claimant SSN: [ ] [ ] [ ] - [ ] [ ] - [ ] [ ] [ ] [ ]

Claimant 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 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 (mm/dd/yyyy)		
a	<input type="checkbox"/> Continuous Leave <i>Completely unable to work for consecutive, uninterrupted days.</i>				
b	<input type="checkbox"/> Intermittent Leave/Reduced Leave Schedule <i>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.</i>	<u>Start Date</u> (mm/dd/yyyy)	<u>End Date</u> (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)	<u>Freq. of Episode</u>	<u># times</u>	<u>Per Week</u>	<u>Per Month</u>
		<u>Length of episode:</u>	<u># Full day(s)</u> (minimum leave increment is 1 day)		

**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.

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

Provider's First & Last Name:		Professional Designation (Ex: MD, DO, PA, CNM)	
Phone #:		License State:	
Fax #:		License #:	
Mailing Address: (Practice name, Street address, City, State, 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.

<b>Health Care Provider's Signature</b>	<b>Date Signed</b>
	[ ] [ ] / [ ] [ ] / [ ] [ ] [ ] [ ] MONTH DAY YEAR

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

**INSTRUCTIONS**

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

**Eligibility for Direct Deposit:** ShelterPoint Life Insurance Company (SPL) and ShelterPoint Insurance Company (SPI) (collectively, the "Companies" and each, a "Company") each offer direct deposit for statutory claim payments. A Company shall be legally recognized and deemed an active party to this agreement in jurisdictions where their involvement is required or legally recognized with all associated rights and obligations. Each Company is independent with respect to the other and is solely responsible for its own performance and neither Company shall have any authority to bind the other or incur obligations on the other's behalf.

Direct deposit, for statutory claim payments, is only available where benefit payments are being issued directly to a claimant/employee. Direct deposit is **not** available if statutory benefits are being issued to an Employer.

In the event that a direct deposit payment is rejected by a bank, 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](http://www.shelterpoint.com)
- Email to: [claimforms@shelterpoint.com](mailto:claimforms@shelterpoint.com)
- Fax to: 516-504-6414
- Mail to: ShelterPoint, 1225 Franklin Avenue - Suite 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)**

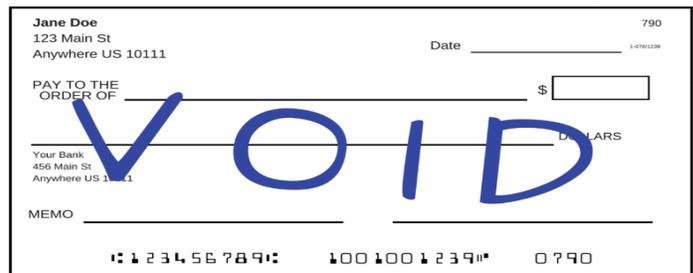
1. <b><u>Claimant Name (First name, Last name)</u></b>	2. <b><u>Social Security Number or I-TIN</u></b> (9 digits)
3. <b><u>ShelterPoint Life Claim Number(s)</u></b>	
4. <b><u>Account Type:</u></b> <input type="checkbox"/> Checking Account <input type="checkbox"/> Savings Account	

**ATTACH PROOF OF BANK ACCOUNT INFORMATION**

Examples of valid proof of banking include:

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

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



**AUTHORIZATION AND SIGNATURE**

I authorize the applicable Company to deposit any benefits I am eligible to receive directly into the bank and account indicated or to such other account as the bank or any successor bank designates as my account. I also authorize the applicable 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 my successful direct deposit enrollment 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. Lastly, should I become eligible for claim payments under multiple, separate and distinct claims, my successful enrollment shall apply to all approved claims.

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

<b>Claimant Signature</b>	<b>Date (mm/dd/yyyy)</b>
---------------------------	--------------------------