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
ShelterPoint Insurance Company

Request for Oregon Paid Family and Medical Leave (PFML)

Claim number:

OREGON SAFE LEAVE CERTIFICATION

Safe Leave allows an eligible individual to take reasonable leave from employment for any of the following purposes related to or resulting from domestic violence, sexual assault, harassment, or stalking:

(1) To seek legal or law enforcement assistance or remedies to ensure the health and safety of the Claimant or the Claimant's minor child or dependent, including preparing for and participating in protective order proceedings or other civil or criminal legal proceedings

(2) To seek medical treatment for or to recover from injuries caused by domestic violence or sexual assault to or harassment or stalking of the eligible Claimant or the Claimant's minor child or dependent.

(3) To obtain, or to assist a minor child or dependent in obtaining, counseling from a licensed mental health professional related to an experience of domestic violence, harassment, sexual assault or stalking.

(4) To obtain services from a victim services provider for the eligible Claimant or the Claimant's minor child or dependent.

(5) To relocate or take steps to secure an existing home to ensure the health and safety of the eligible Claimant or the Claimant's minor child or dependent.

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

Claimant Information (to be completed by the individual requesting Safe 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: *(9 digits)*

☐☐☐ - ☐☐ - ☐☐☐☐

4. Claimant's Date of Birth:

☐☐ / ☐☐ / ☐☐☐☐

month *day* *year*

5. Claimant's Gender

☐ Male
☐ Female
☐ Not Designated/Other

6. Reason for Safe Leave Request: (one or more options may be selected)

☐ Safe Leave to care for my Child*
Child's Age: _____

Select type of care provided:
☐ Seek medical care for my child, (including counseling) for physical or psychological injury or disability or to aid Child in recovery from injuries caused by domestic violence, sexual assault, harassment, or stalking.
☐ Obtain services for my child from a victim services provider
☐ Relocate my child or take steps to secure an existing home
☐ Participate in and/or support my child during civil, criminal, or administrative proceedings related to or resulting from the domestic violence, sexual assault, harassment, or stalking.

**Child is an individual described in ORS 657B.010 (a) – (c) and is Under the age of 18; or Age 18 or older as an adult dependent substantially limited by a physical or mental impairment as defined in ORS 659A.104.*

☐ Safe Leave **for myself** to seek **medical care** (including counseling) for physical or psychological injury or disability **or** to **recover from injuries** caused by domestic violence, sexual assault, harassment, or stalking.

☐ Safe Leave **for myself** to
☐ Obtain services from a victim services provider
☐ Relocate or take steps to secure an existing home
☐ Participate in civil, criminal, or administrative proceedings related to or resulting from the domestic violence, sexual assault, harassment, or stalking.

Form continues on next page

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

Claimant Address: _____

Safe Leave Required Documentation

Please include at least one (1) of the below documents with this application to support the request for leave:

☐ A copy of a police report, or a formal complaint to a school's Title IX Coordinator indicating that you or your child were a victim of domestic violence, harassment, sexual assault, or stalking

☐ A copy of a protective order, or other evidence that you or your child appeared in or were preparing for a civil, criminal, or administrative proceeding related to domestic violence, harassment, sexual assault, or stalking

☐ Written documentation from an attorney, law enforcement officer, health care provider, licensed mental health professional or counselor, member of the clergy, or victim services provider that affirms you or your child were undergoing treatment or counseling, obtaining services, or relocating as a result of domestic violence, harassment, sexual assault, or stalking.

Written Description of the Purpose for This Leave (to be completed by the claimant if no other documentation is available)

If none of the above documentation is available for good cause (e.g. due to a lack of access to services, or concerns for the safety of the claimant or claimant's child), the claimant may provide a signed written statement certifying that they are taking leave for one of the following reasons:

1. To seek medical care or psychological or other counseling for physical or psychological injury or disability,
2. To obtain services from a victim services organization,
3. To relocate due to domestic violence, harassment, sexual assault, or stalking,
4. To participate in any civil or criminal proceedings related to or resulting from domestic violence, harassment, sexual assault, or stalking.

_____

_____

_____

_____

_____

_____

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)

Third Party Signature

I attest I am ☐ an Attorney, ☐ an Employee of the Judicial Branch's Office of the Victim Services or the Office of the Victim Advocate, or ☐ a licensed medical professional or ☐ other licensed professional. I am attesting that the above-named individual is a victim of domestic violence, harassment, sexual assault, or stalking.

Print Name	**Organization Name**
Signature	**Date Signed** ☐☐ / ☐☐ / ☐☐☐☐ (month / day / year)

End of OR PFML - Safe Leave Certification 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

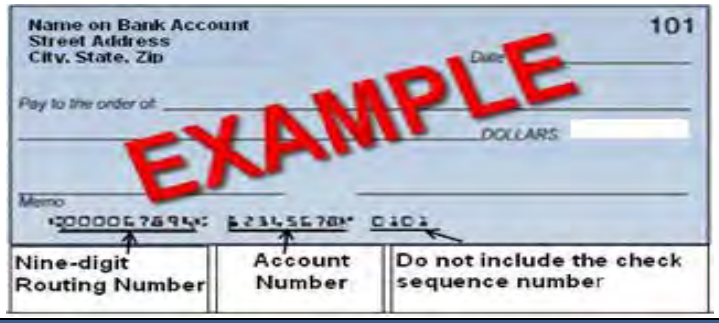
☐ Checking Account ☐ Savings Account

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)**