

Checklist for requesting Maine Paid Family and Medical Leave (ME PFML)**Before you apply for ME PFML:**

- Check eligibility requirements for leave.**
- Plan your leave.** Leave can be taken as continuously, intermittently, or on a reduced leave schedule, in accordance with the ME PFML and/or private plan PFML policy. The minimum time increment is one (1) hour.
- Notify your ME employer** in writing at least 30 calendar days before the start of leave (if the leave is foreseeable) Otherwise, notify your employer as soon as possible! An employee must give reasonable notice to the employee's employer of the employee's intent to use leave. Thirty days' written notice to the employer shall be presumed to constitute reasonable notice.

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

Please print information clearly. Incomplete or illegible claim packages may delay processing.

- Complete Claimant's Statement, in full.** Sign and date the form, retain a copy of your files.
- Your ME employer completes the Employer's Statement, in full.** They should make a copy of their files and return the employer's complete statement to you.
- Complete the Certification or Attestation for your leave type (options on page 2) and attach supporting documentation as required.**

Submit fully completed claim package and supporting documentation to ShelterPoint or your employer's current ME PFML administrator.

The completed claims for ME PFML benefits can be submitted to ShelterPoint by any of the listed methods below (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 Life, 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 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.**

Claims should be submitted no earlier than 60 days before the anticipated start of leave and no later than 90 days after the 1st confirmed day of leave, to avoid losing benefits. If benefits are paid to you more than the amount to which you are entitled to, you must return the overpaid amount to the payor of such benefits.

By completing and filing your application for Paid Family and Medical 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 false statements or other failure to provide truthful, accurate and complete information may result in monetary and other penalties as well as the possibility of criminal prosecution.

Checklist for requesting Maine Paid Family and Medical Leave (ME PMFL)**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 ME – PFML - BONDING CERTIFICATION form.
 - Attach documentation as listed on the form, supporting your relationship with the new child.

- Medical Leave due to your own serious health condition** (including pregnancy/post-partum)
 - 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 ME – PFML - MEDICAL CERTIFICATION – SELF CARE form.
 - Your health care provider completes the remainder of the MEDICAL CERTIFICATION – SELF CARE form and returns the completed form to you.

- Caring for a family member with 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 ME - MEDICAL CERTIFICATION – FAMILY CARE form, providing information on yourself and your qualifying family member requiring care.
 - Your family members health care provider completes the remainder of the ME - MEDICAL CERTIFICATION – FAMILY CARE form and returns the completed form to you.

- Caring for a family member with active service injury or illness**
 - Your family member needs to complete the HIPAA Authorization and provide it to their health care provider, allowing medical information to be shared with you and ShelterPoint.
 - Complete the top portion of the ME – MEDICAL CERTIFICATION – MILITARY CAREGIVING form, providing information on yourself and your qualifying family member requiring care.
 - Your family member’s provider completes the remainder of the Medical Certification form and returns to you in a timely fashion.

- Qualifying exigencies associated with a call to active duty overseas**
 - Complete the ME – PFML - MILITARY EXIGENCY ATTESTATION form.
 - Attach proof documents supporting the leave (options listed on the form)

- Safe Leave**
 - Complete the ME – PFML – SAFE LEAVE ATTESTATION form
 - Attach proof documents supporting the leave (options listed on the form)

End of ME PFML Claim Checklist

Claim Number: _____

CLAIMANT STATEMENT

This Application ("Claimant Statement") is completed by the individual that is requesting paid leave benefits (the "Claimant" or "Employee"). Applications may be filed up to 60 days prior to the start of the requested leave, and up to 90 days after the start of the leave. A fully complete application for benefits includes a claimant statement, employer statement, certification/attestation 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/FI), City, State, Zip):

Street address _____

City, State Zip _____

3. Claimant's Social Security Number or I-TIN:

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

4. Claimant's Date of Birth:

<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>

5. Claimant's Gender:

- Male
- Female
- Not Designated/Other

6. Claimant's Primary Contact Phone Number & Type:

() -

area code

- Mobile/Cellular Phone Home Phone Work Phone

7. Claimant's Contact Email Address:

By providing your contact information, you consent to Us contacting you by any of the methods provided.

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 family member due to domestic violence, harassment, sexual assault, or stalking
- Military Exigency
- Military Caregiving

9. Family Member's Relationship* to the Claimant is:

- | | |
|---|--------------------------------------|
| <input type="checkbox"/> Self | <input type="checkbox"/> Child |
| <input type="checkbox"/> Spouse | <input type="checkbox"/> Grandparent |
| <input type="checkbox"/> Domestic Partner | <input type="checkbox"/> Grandchild |
| <input type="checkbox"/> Parent | <input type="checkbox"/> Sibling |
- 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:

.....

.....

* "Relationship" includes "biological, foster, adoptive, defacto, step, legal guardian, and in loco parentis relationships and the same relationships to the Claimant's spouse or domestic partner, if applicable.

Form continues 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 ShelterPoint (and your employer) as soon as possible. You may not request any leave prior to the start of the ME PFML program (05/01/2026) Or the effective date of your Employer's Plan, whichever is later.*

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 time increment (1) hour.

Leave Start Date

Enter the first date you are requesting INTERMITTENT leave from work.

/ /
month day year

Date(s) & Hour(s) Requested:

Reduced Leave Schedule:

A consistent but reduced work schedule for multiple weeks. Minimum time increment (1) hour.

Leave Start Date

Enter the first date you are requesting REDUCED LEAVE from work.

/ /
month day year

Frequency of leave: (e.g., 4 hours per day or 2 days per week. Be specific)

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 written notice to your employer. Unforeseeable leave (emergency basis or unexpected) requires notice to your employer as soon as practicable.

a. Was 30 days' advanced notice provided to your employer for this leave? Yes No

b. Date notice was provided to employer: / /
month day year

c. If 30 days' advance notice was not provided, explain why:

12. Other Types of Leave:

Provide details 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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>
b. Workers' Compensation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>
c. ME PFML	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>
d. ME – LTD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>
e. FMLA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>

Form continues next page.

Claimant Name: _____ Claimant SSN: _____

Claimant Address: _____

Employment Information

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

KEY TERMS:

Benefit year: means the 12-month period beginning on the first day of the calendar week immediately preceding the first date of approved Paid Family or Medical Leave.

Base period: means the first 4 of the last 5 completed calendar quarters immediately preceding the first day of an individual's benefit year.

Wages: include, but are not limited to salary, wages, tips, commissions and bonuses, severance pay, remuneration for services which are subject to Maine unemployment tax, and other compensation as determined by rule.

Example: Cindy requests ME PFML bonding leave with a leave start date of **07/01/2026**. Her benefit year will begin on 07/01/2026. Cindy's base period for reporting wages is the **first (4) of the previous (5) completed quarters**. Based on her start date, the lookback quarters are 1. 4/1/2025 – 6/30/2025. 2. 7/1/2025 – 9/30/2025. 3. 10/1/2025 – 12/31/2025. 4. 1/1/2026 – 3/31/2026. 5. 4/1/2026 – 6/30/2026. The employee's average weekly wage (AWW) is calculated by dividing the 4 quarters earnings by 52 weeks.

During the first 4 quarters of the based period, Cindy earned \$70,000, divided by 52 weeks, making her average weekly wage (AWW) to \$1,346.15.

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

If you had more than one Maine employer in the base period (the first four of the last five completed calendar quarters preceding the benefit year), name all employers. Looking back to the previous 4 of the last 5 completed quarters prior to your application for leave, determine the quarter in which your wages were highest, and report that value in the "Gross Wages" column. You may be asked to provide supporting documentation of wages. 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>	Employment date(s) <small>(MM/DD/YYYY)</small>	Days of the Week usually worked:	Gross (\$) Wages in Base Period
			Hire Date: Last Day Worked:	<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 ME Employer(s)

If there are more than 3 recent ME Employers, please include details on a separate sheet.

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>	Employment date(s) <small>(MM/DD/YYYY)</small>	Days of the Week usually worked:	Gross (\$) Wages in Base Period
			Hire Date: Last Day Worked:	<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	
			Hire Date: Last Day Worked:	<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	

Form continues 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 leave schedule, will be provided to the employer.

14. Please choose your preference for receiving benefit payments. 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 is 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

Attestation and Signature:

NOTICE It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, or a denial of insurance benefits.

I am hereby making a request for benefits under the Maine Paid Family and Medical Leave Insurance Program. 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 ME PFML - Claimant Statement.

Employee's Legal Name:
Employee's Mailing Address:

Employee's SSN:

Employer Information- Continued from previous page

11. Employee's job title

12. Employee's normal working schedule and hours worked

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

Average # of workdays per work week: _____

Mon Tue Wed Thur Fri Sat Sun

b. Provide the scheduled work hours for the last 4 weeks the employee reported to work prior to the last day worked before leave.

Week #	Scheduled Weekly Hours Worked (e.g. 40 hours)
Week 1	_____
Week 2	_____
Week 3	_____
Week 4	_____
Average	_____

13. Provide the employees' wages during the base period:

Benefit year: means the 12-month period beginning on the first day of the calendar week immediately preceding the first date of approved Paid Family or Medical Leave.

Base period: means the first 4 of the last 5 completed calendar quarters immediately preceding the first day of an individual's benefit year.

Wages: Includes, but is not limited to salary, wages, tips, commissions and bonuses, severance pay, remuneration for services which are subject to Maine unemployment tax, and other compensation as determined by rule.

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

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

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.
 / /

- Leave End Date
Enter the last date the EE is requesting continuous leave through.

/ /

month day year 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

Leave Start Date
Enter the first date the EE is requesting intermittent leave from work.

/ /

month day year

List all dates/hours requested:

Reduced Leave Schedule:
A consistent but reduced work schedule for multiple weeks.

Leave Start Date
Enter the first date the EE is requesting reduced leave from work.

/ /

month day year

Frequency of leave: (e.g., 2 days per week, or 4 hours per day, or every Monday)

15. Was 30 days' advance notice given to you by the employee requesting foreseeable leave?

Yes No **Date notice provided to employer** **Detail:**

/ /

month day year

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

Yes No

Form continues next page.

Employee's Legal Name:
Employee's Mailing Address:

Employee's SSN:

Employer Information - Continued from previous page

16. Has the employee received or claimed any of the following benefits in the preceding 52 weeks? Provide details below, and any supporting documentation pertaining to the type of benefit received/claimed.

Benefit Type	received	claimed	from (mm/dd/yyyy)	through (mm/dd/yyyy)
a. Unemployment benefits	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	- <input type="text"/>
b. Workers' Compensation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	- <input type="text"/>
c. ME PFML	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	- <input type="text"/>
d. ME – LTD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>
e. FMLA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>

17. Employment Benefits

“**Employment Benefits**” means all benefits provided or made available to Employees by an Employer, including, but not limited to, group life insurance, health insurance, disability insurance, sick leave, annual or vacation leave, educational benefits and pensions.

a. Will the employee be using any employment benefits **during the leave period requested?**

Yes (answer question b) No (go to question # 19)

b. Will the employee be receiving wage replacement **during all or a portion of the leave period requested?**

Yes – (answer question i and ii) No (go to question # 19)

i. provides details of the type of wage replacement and the date(s) it will be paid for:

ii. are you requesting reimbursement* for advance payment of PFML benefits? Yes No

Note:

Employer reimbursement may be permitted if the employee's salary is continued through some kind of benefit payments made by the employer. Employer reimbursement is **not permitted** if the employee is using **any employer-provided paid leave** such as use of accrued vacation, sick, personal, or parental leave.

18. ME PFML Policy #:

Attestation and Signature

NOTICE It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, or a denial of insurance benefits.

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

Signature

Title

Date (mm/dd/yyyy)

<input type="text"/>	/	<input type="text"/>	/	<input type="text"/>	<input type="text"/>	<input type="text"/>
month		day		year		

End of ME 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)

First name _____ Middle initial _____ Last name _____

2. Mailing Address of Individual Receiving Care (Street Address (including Apt/FI), City, State, Zip):

Street address _____

City, State Zip _____

3. Care Recipient’s Contact Phone #:

() -

area code

4. Care Recipient’s Date of Birth:

/ /

MONTH DAY YEAR

Health Care Provider Information

5. Name of Care Recipient’s Health Care Provider (include full professional designation, i.e., MD, DO):

6. Mailing Address of Health Care Provider (Street Address (including Apt/FI), 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 PFML is being requested to the paid family and medical leave (“PFML”) insurance carrier listed below.

Carrier Name: SHELTERPOINT LIFE INSURANCE COMPANY
Carrier Address: 1225 Franklin Avenue, Suite 475, Garden City NY 11530

Unless I have put a check by the information that may be disclosed, I do NOT want my Health Care Provider to disclose the following types of information:

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

Form continues 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"/>	<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

MEDICAL CERTIFICATION – MILITARY CAREGIVING FORM

Employee Information (to be completed by the employee requesting leave to care for a military member with serious health condition)

1. Employee's Legal Name (First Name, Middle Initial, Last Name)																		
<i>First name</i>	<i>Middle initial</i>	<i>Last Name</i>																
2. Employee's Mailing Address (Street Address (including Apt/FI), City, State, Zip)																		
<i>Street address</i>																		
<i>City, State Zip</i>																		
3. Employee's Social Security Number or TIN		4. Employee's Date of Birth <small>(mm/dd/yyyy)</small>																
<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="border: 1px solid black; width: 25px; height: 25px;"></td> <td style="border: 1px solid black; width: 25px; height: 25px;"></td> <td style="border: 1px solid black; width: 25px; height: 25px;"></td> <td style="border: 1px solid black; width: 25px; height: 25px;"></td> <td style="border: 1px solid black; width: 25px; height: 25px;"></td> <td style="border: 1px solid black; width: 25px; height: 25px;"></td> <td style="border: 1px solid black; width: 25px; height: 25px;"></td> <td style="border: 1px solid black; width: 25px; height: 25px;"></td> </tr> </table>										<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="border: 1px solid black; width: 30px; height: 25px;"></td> <td style="border: 1px solid black; width: 30px; height: 25px;"></td> <td style="border: 1px solid black; width: 30px; height: 25px;"></td> <td style="border: 1px solid black; width: 30px; height: 25px;"></td> </tr> <tr> <td style="text-align: center; font-size: 8px;">MONTH</td> <td style="text-align: center; font-size: 8px;">DAY</td> <td colspan="2" style="text-align: center; font-size: 8px;">YEAR</td> </tr> </table>					MONTH	DAY	YEAR	
MONTH	DAY	YEAR																

Service Member Information (Military service member requiring care due to their serious health condition)

1. Service Member's Legal Name (First Name, Middle Initial, Last Name)		
<i>First name</i>	<i>Middle initial</i>	<i>Last Name</i>
2. Service Member's Mailing Address (Street Address (including Apt/FI), City, State, Zip)		
<i>Street address</i>		
<i>City, State Zip</i>		
3. Service Member's Relationship to Employee (Claimant) Requesting Leave		
<input type="checkbox"/> Child (of any age) <input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Parent		
4. Service Member Affiliation		
<input type="checkbox"/> Air Force <input type="checkbox"/> Army <input type="checkbox"/> Coast Guard <input type="checkbox"/> Marine Corps <input type="checkbox"/> Navy <input type="checkbox"/> Reserves <input type="checkbox"/> National Guard		
5. Provide details on the type of care the service member will need		
<input type="checkbox"/> Assistance with basic medical, hygiene, nutritional, of safety needs <input type="checkbox"/> Transportation <input type="checkbox"/> Physical Care <input type="checkbox"/> Psychological Comfort <input type="checkbox"/> Death <input type="checkbox"/> Other (please describe): <hr/> <hr/> <hr/>		

Form continues next page.

Employee Name: _____ Employee SSN: _____

Employee Address: _____

MEDICAL CERTIFICATION (to be completed by service member's treating health care provider)

A family member of your patient has made a request to be absent from work to care for your patient. For us to make a decision on their claim for ME Paid Family and Medical Leave benefits for the care of your patient, we will need you to complete the information in this form. When completing this certification, we ask:

- Your answers are to be your best estimate based on your medical knowledge, experience, and examination of the patient.
 - Please note, health care providers may only certify the need for leave if such certification is within the diagnostic scope of their licensure, certification, or registration.
- Be as specific as you can. Using terms like "as needed", "unknown" or "indeterminate" may not be enough to approve the claim.
- Limit your responses to the health condition for which their family member is seeking leave.

Serious Health Condition: means an illness, injury, impairment, pregnancy, recovery from childbirth or physical, mental, or psychological condition that involves inpatient care in a hospital, hospice or residential medical care center or continuing treatment by a Health Care Provider.

MEDICAL CERTIFICATION (to be completed by the family member's treating health care provider)

1. Medical Information:

a.	What was the first date on which the patient's health condition commenced?	<table border="1"><tr><td> </td><td> </td><td>/</td><td> </td><td> </td><td>/</td><td> </td><td> </td><td> </td><td> </td></tr><tr><td colspan="2">month</td><td></td><td colspan="2">day</td><td></td><td colspan="4">year</td></tr></table>			/			/					month			day			year			
		/			/																	
month			day			year																
b.	What is the probable duration of the health condition? (e.g., 3 months; 2 weeks)																					
c.	For the health condition for which your patient is requesting time away from work, is it your belief that the health condition was caused by or otherwise related to a workplace injury or illness?	<input type="checkbox"/> Yes <input type="checkbox"/> No																				
d.	Which of the following apply to the patient's health condition? Check all that apply and provide specifics regarding dates.																					
<input type="checkbox"/>	Inpatient Care – The patient <input type="checkbox"/> was/ <input type="checkbox"/> is/ <input type="checkbox"/> will be admitted for an overnight stay in a hospital, hospice, or residential medical care facility on the following dates: <ul style="list-style-type: none">• Admit Date(s): _____• Discharge Date(s) _____																					
<input type="checkbox"/>	Incapacity Plus Treatment (e.g., outpatient surgery, strep throat) Answer i. through iii. below																					
<input type="checkbox"/>	i. Due to the patient's health condition, the patient <input type="checkbox"/> was/ <input type="checkbox"/> is/ <input type="checkbox"/> will be incapacitated for more than three consecutive, full calendar days																					
<input type="checkbox"/>	ii. The patient <input type="checkbox"/> was/ <input type="checkbox"/> is/ <input type="checkbox"/> will be seen on the following date(s): Visit/Treatment Date(s): _____																					
<input type="checkbox"/>	iii. The health condition <input type="checkbox"/> had/ <input type="checkbox"/> has/ <input type="checkbox"/> will also result(ed) in a course of continuing treatment under the supervision of a health care provider (e.g., prescription medication (other than over the counter), therapy requiring special equipment, etc.)																					
<input type="checkbox"/>	Pregnancy - The health condition is pregnancy																					
<input type="checkbox"/>	Chronic Health Conditions - (e.g., asthma, migraine headaches) Treatment visits are expected to be at least twice per year																					
<input type="checkbox"/>	Permanent or Long-Term Health Conditions - Due to the health condition, incapacity is permanent or long term and requires the continuing supervision of a health care provider (even if active treatment is not being provided).																					
<input type="checkbox"/>	Health Conditions requiring Multiple Treatments - (e.g., chemotherapy treatments, restorative surgery, etc.) Due to the health condition, it is medically necessary for the patient to receive multiple treatments.																					
<input type="checkbox"/>	None of the above - If none of the above six categories is checked, (i.e., inpatient care, pregnancy) no additional information is needed. Please sign and date the form on page 3.																					

2. Diagnosis/Analysis: Provide the relevant medical facts relating to the health condition requiring this leave (these facts may include diagnosis, symptoms, or any regimen of continuing treatment such as the use of specialized equipment):

Diagnosis code(s):

Form continues next page.

Employee Name: _____ Employee SSN: _____

Employee Address: _____

Signs & symptoms:

Objective findings:

3. Care Needs of the Patient: To qualify for benefits, care of the patient must be medically necessary. Select the type of care needed by the patient or provide a brief description in the space below (e.g., assistance with basic medical, hygienic, nutritional, safety, transportation needs, physical care, or psychological comfort).

- Assistance with basic medical, hygienic, nutritional, or safety needs
- Physical care
- Psychological comfort
- Transportation
- Death
- Other (please describe): _____

MEDICAL CERTIFICATION - (to be completed by the family member's treating health care provider)

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

<input type="checkbox"/> Continuous Leave My patient has/will be incapacitated for a single continuous period due to their own health condition, including time for treatment and recovery.	Start Date	End Date	
<input type="checkbox"/> Reduced Work Schedule Leave My patient will need to work a reduced work schedule due to their own health condition and associated treatment and recovery period.	Start Date	End Date	Work Capacity The patient is able to work up to ____ hours per week.
<input type="checkbox"/> Intermittent Leave My patient is expected to have periodic flare-ups or follow-up treatment appointments where intermittent absence from work will be medically necessary.	Start Date	End Date	Incapacity The Patient's incapacity may occur up to ____ hours per week.

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

Health Care Provider's First & Last Name:	Professional Designation: (e.g., MD, DO, PA, CNM)
Phone Number:	Specialty/Board Certification:
Fax Number:	License Number and State:
Business Address: (Practice name, Street address, City, State, Zip)	National Provider Identifier (NPI) Number:

Certification and Signature

NOTICE It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, or a denial of insurance benefits.

My signature certifies 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, that I am a health care provider authorized to certify their health condition within the scope of my licensure, and that the patient is not one of my family members.

Health Care Provider's Signature

Date Signed

		/			/				
MONTH			DAY			YEAR			

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
- Email to: 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)

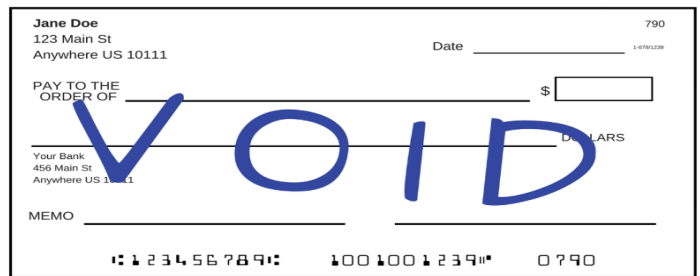
1. <u>Claimant Name (First name, Last name)</u>	2. <u>Social Security Number or I-TIN</u> (9 digits)
3. <u>ShelterPoint Life Claim Number(s)</u>	
4. <u>Account Type:</u> <input type="checkbox"/> Checking Account <input type="checkbox"/> Savings Account	

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.

Claimant Signature	Date (mm/dd/yyyy)
---------------------------	--------------------------