

**Checklist for Requesting Minnesota Paid Family and Medical Leave (MN PFML)****Before you apply for MN PFML:**

- Check eligibility requirements for leave.**
- Plan your leave.** Leave can be taken continuously, intermittently, or on a reduced leave schedule.
- Notify your MN employer** at least 30 calendar 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 Claimant's Statement, in full.** 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 MN employer completes the Employer's Statement, in full.** They should make a copy of the claim for their files, and return the completed employer's statement to you.
- Complete the certification for your leave type (options on page 2) and attach supporting documentation.**

**Submit fully completed claim package to ShelterPoint(your employer's current MN PFML carrier):**

Completed claims for MN 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 Life, 1225 Franklin Ave-Ste 475, Garden City NY 11530

Web address: [shelterpoint.com/MN-ps](http://shelterpoint.com/MN-ps)

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.**

Claims should be submitted no later than 30 calendar days after the 1<sup>st</sup> confirmed day of leave, to avoid losing benefits. 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 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. *A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime*

**Checklist for Requesting Minnesota Paid Family and Medical Leave (MN 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 MN – PFML - BONDING CERTIFICATION form
  - Attach documentation as listed on the form, supporting your relationship with the 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 MN – 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 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 MN - 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 MN - MEDICAL CERTIFICATION – FAMILY CARE form and returns the completed form to you.
  
- Military Exigency Leave**
  - Complete the MN – PFML - MILITARY EXIGENCY form
  - Attach proof documents supporting the leave (options listed on the form)
  
- Safe Leave**

Allows a covered individual (“Claimant” or “employee” or “You”) to take leave from employment for any of the following purposes for You or a Family Member related to or resulting from domestic abuse, sexual assault or abuse, harassment, or stalking:

  - Complete the MN – PFML – SAFE LEAVE form
  - Attach proof documents supporting the leave (options listed on the form)

End of MN PFML Claim Checklist



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), intermittently, or reduced leave. 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

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 for multiple weeks

Leave Start Date

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

/  /   
month                      day                      year

Frequency of leave: ((e.g., number of 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 notice to your employer. Unforeseeable leave (emergency basis or unexpected) requires notice to your employer as soon as practicable.

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 (CSEA)	<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. MN PFML	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>

Form continues on next page

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

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

## Employment Information

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

**KEY TERMS:**

**Benefit year:** means the period of 52 calendar weeks beginning the effective date of leave under Minnesota Statute Section 268B.04, except as provided in paragraphs (b) to (d) of Minnesota Statute Section 268.01 Subd. 8 (b) to (d).

**Base period:** The most recent four quarters in which Wage credits were earned with the current Employer before an employee applies for benefits, as outlined in Minnesota Statute Section 268.01 Subd. 5 (e).

**Wages:** means all compensation for employment, including commissions; bonuses, awards, and prizes; severance payments; standby pay; vacation and holiday pay; back pay as of the date of payment; tips and gratuities paid to an employee by a customer of an employer and accounted for by the employee to the employer; sickness and accident disability payments, except as otherwise provided in Minnesota Statute Section 268.01 Subd. 29, and the cash value of housing, utilities, meals, exchanges of services, and any other goods and services provided to compensate an employee, except as outlined in Minnesota Statute 268.01 Subd 29 (1) through (17).

**Wages does not include:** Payments for retirement (such as contributions to a pension, annuity, or 401(a) trust), payments for medical and hospitalization expenses, disability payments, or death benefits that are part of a plan for employees in general, sick pay (paid after six calendar months from the employee's last day of work), the value of a special employee discount for goods or services (if the purchase is optional), reasonable and customary director's fees for individuals who are not otherwise employees, travel and expense reimbursements, payments made by an employer for a domestic or agricultural employee's portion to Social Security tax, and the value of employer-provided parking facilities as outlined in Minnesota Statute Section 268.01 Subd. 29.

**Example:** Cindy requests MN PFML bonding leave with a leave start date of 02/14/2026. Her benefit year will begin on 02/14/2026. Cindy's base period for reporting wages is the last (4) quarters in which Wages were earned. Based on her start date, the lookback quarters are 1. 01/01/2025 – 03/31/2025 2. 04/1/2025 – 06/31/2025 3. 07/1/2025 – 09/30/2025 4. 10/01/2025-12/31/2025. The gross wages from the highest quarter during these 4 quarters (10/01/2023-09/30/2024) will be used to determine her average weekly wage (AWW).

Cindy's highest quarter earnings during the base period were in Q4 2025 when she earned \$14,000.00, making her AWW \$1,076.92. This AWW will be used to calculate her weekly benefit rate under MN PFML.

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

If you had more than one employer in the base period (the last four calendar quarters in which Wage credits were earned), name all employers. Looking back to the previous 4 calendar quarters prior in which you earned Wage credits, 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 4 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)	Employment date(s) (MM/DD/YYYY)	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 MN Employer(s)**

If more than three (3) recent MN Employers, please include details on a separate sheet.

Business Name, Address/City/St/Zip, Tax ID #	Avg # hours/week (e.g. 40 hrs/wk)	Avg # days/week (e.g. 5 days/wk)	Employment date(s) (MM/DD/YYYY)	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	
Business Name, Address/City/St/Zip, Tax ID #	Avg # hours/week (e.g. 40 hrs/wk)	Avg # days/week (e.g. 5 days/wk)	Employment date(s) (MM/DD/YYYY)	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	

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 leave schedule, will be provided to the employer.*

**14. 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 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** A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime."

*I am hereby making a request for benefits under the Minnesota 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 MN PFML - Claimant Statement.



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

Employer Statement continues on next page.

**Employer Information - Continued from previous page**

<p><b>10. Employee's Job Title/Description of duties</b></p>	<p><b>11. Employment status for the employee requesting leave</b></p> <p>Date employed: _____ <small>mm/dd/yyyy</small></p> <p>In active employment: <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p style="text-align: center;">↓</p> <p>Termination Date: _____ <small>mm/dd/yyyy</small></p>
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**12. Will Leave be Utilized Continuously or Intermittently or on a Reduced Leave Schedule? Provide Details Below. Any changes to your leave plans and/or estimated dates must be communicated/confirmed as soon as possible to us and your employer.**

**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.

<small>month</small>		<small>day</small>		<small>year</small>		

Leave End Date

Enter the last date you are requesting continuous leave through

<small>month</small>		<small>day</small>		<small>year</small>		

**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 you are requesting INTERMITTENT leave from work.

<small>month</small>		<small>day</small>		<small>year</small>		

Additional Leave Dates Requested

**Reduced Leave Schedule:**

A consistent but reduced work schedule for multiple weeks

Leave Start Date

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

<small>month</small>		<small>day</small>		<small>year</small>		

Frequency of leave: (Number of days per week. Be Specific)

**13. Was 30 days advance given to you by the employee requesting foreseeable leave?**

**Yes**      Date notice provided to employer (mm/dd/yyyy)     

**No**      Date notice provided to employer: (mm/dd/yyyy)     

↓

Detail:

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

**Yes**     **No**

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

Benefit Type	received	claimed	from (mm/dd/yy)	through (mm/dd/yy)	
a. Unemployment benefits	<input type="checkbox"/>	<input type="checkbox"/>	<input style="width: 50px; height: 20px;" type="text"/>	-	<input style="width: 50px; height: 20px;" type="text"/>
b. Workers' Compensation	<input type="checkbox"/>	<input type="checkbox"/>	<input style="width: 50px; height: 20px;" type="text"/>	-	<input style="width: 50px; height: 20px;" type="text"/>
c. MN PFML	<input type="checkbox"/>	<input type="checkbox"/>	<input style="width: 50px; height: 20px;" type="text"/>	-	<input style="width: 50px; height: 20px;" type="text"/>
d. Other (Sick/Vacation/PTO or other employer provided leave. Please specify.)	<input type="checkbox"/>	<input type="checkbox"/>	<input style="width: 50px; height: 20px;" type="text"/>	-	<input style="width: 50px; height: 20px;" type="text"/>

Employer Statement continues on next page.

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

**Employer Information - Continued from previous page**

**15. Will the employee receive any wages or other benefits (see above) during any part of the requested leave period?**

Yes       No

↓

Provide exact dates and type of wages or benefits received on a separate sheet.

**16. Is the employee taking FMLA concurrently with this leave?**

Yes       No

**17. Employee & Employer Contributions:** ShelterPoint will rely on and use the information you provide in response to these questions to determine the amount of tax, if any, it is required to withhold from any claim payments.

**a.** Does the employee contribute to the cost of the MN Paid Medical leave (PML) coverage?

**I.** If yes, what percentage of the overall MN PML premium does the employee pay?  
*If left blank, we will assume the employee contributes the maximum allowable.*

\_\_\_\_\_ %

Yes       No

Answer I. below      Skip a.I and go to question 17.b.

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**b.** Does the employee contribute to the cost of the MN Paid Family Leave (PFL) coverage?

**I.** If Yes, what percentage of the overall MN PFL premium does the employee pay?  
*If left blank, we will assume the employee contributes the maximum allowable.*

\_\_\_\_\_ %

Yes       No

Answer I. below      Skip b.I and go to question 18.

**18. ShelterPoint MN PFML Policy #:**

**Declaration and Signature**

**NOTICE** A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime."

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

<b>Signature</b>	<b>Date</b> (mm/dd/yyyy)
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End of 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. For leaves to care for your qualified family member or military service 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.

**1. Care Recipient Information**

**Name of Individual to Receive Care ("Care Recipient") (First Name, Middle Initial, Last Name)**

**Mailing address of Individual Receiving Care (Street Address (including apt/fl #), City, State, Zip)**

Street address

City, State Zip

**Care Recipient's Contact Phone #**

**Care Recipient's Date of Birth** (mm/dd/yyyy)

( [ ] [ ] [ ] ) [ ] [ ] [ ] - [ ] [ ] [ ] [ ]  
area code

**2. Health Care Provider Information**

**Name of Care Recipient's Health Care Provider (include full professional designation, i.e. MD, DO)**

**Mailing address of Health Care Provider (Street Address (including apt/fl #), City, State, Zip)**

Street address

City, State Zip

**Health Care Provider's Contact Phone #**

( [ ] [ ] [ ] ) [ ] [ ] [ ] - [ ] [ ] [ ] [ ]  
area code

**3. 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:

- HIV/AIDS related information;
- Mental health information;
- Substance Abuse information;
- Psychotherapy notes

HIPAA Authorization continues on the next page.

**4. 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.

**5. Signature (Page 1 of this form must be completed before signing below)**

<b>Signature of Care Recipient or Care Recipient's Legal Representative</b>	<b><u>Date signed</u></b> (mm/dd/yyyy)
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**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:

**MEDICAL CERTIFICATION – FAMILY CARE LEAVE**  
(Serious Health Condition Certification– Family Member)

**Family Care Leave** allows a covered individual to take leave from employment to care for their qualified family member with a serious health condition. An individual may not exceed 12 weeks of paid leave in a benefit year. Applications may be filed up to 60 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” or “Employee”). 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 family 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:**

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**4. Claimant’s Date of Birth:**

MONTH		DAY		YEAR					

**5. Claimant’s Gender:**

- Male
- Female
- Not Designated/Other

**Family Member Information (covered family member requiring care due to their health condition)**

**1. Family Member’s Legal Name (First Name, Last Name):**

*First Name* \_\_\_\_\_ *Last Name* \_\_\_\_\_

**2. Family Member’s Date of Birth:**

MONTH		DAY		YEAR					

**3. Family Member’s Mailing Address**

*Street address*

*City, State Zip*

**4. The Family Member’s Relationship\* to Claimant:**

- Child  Spouse  Domestic Partner  Parent  Grandparent  Grandchild  Sibling
- Person with whom the employee has a significant bond that is or is like a family relationship

*\*Relationships include “biological, foster, adoptive, step, and in loco parentis relationships and the same relationships to the employee’s spouse or domestic partner, if applicable.*

**MEDICAL CERTIFICATION (to be completed by the family 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 MN 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 ( Minnesota Statutes, sec. 268B.01, subdivision 24,).
- 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.

Do not include 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 employee’s family members, 29 C.F.R. §1635.3(b).

**Serious Health Condition:** means a physical or mental illness, injury, impairment, condition, or substance use disorder that involvest inpatient care in a hospital, or continuing treatment by a Health-Care Provider.

*Form continues on next page*

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

Patient's Name: \_\_\_\_\_ Patient's DOB: \_\_\_\_\_

Continued from prior page

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

**1. Medical Information:**

a.	What was the <b>first date</b> 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? <b>Check all that apply and provide specifics regarding dates.</b>																					
<input type="checkbox"/>	<b>Inpatient Care –</b> The patient <input type="checkbox"/> was/ <input type="checkbox"/> is/ <input type="checkbox"/> will be admitted for an <b>overnight stay</b> in a hospital, hospice, or residential medical care facility on the following dates: <ul style="list-style-type: none"><li>Admit Date(s): _____</li><li>Discharge Date(s) _____</li></ul>																					
<input type="checkbox"/>	<b>Incapacity Plus Treatment</b> (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"/> is/ <input type="checkbox"/> will be incapacitated for more than seven 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"/>	<b>Chronic Health Conditions</b> - (e.g., asthma, migraine headaches) Treatment visits are expected to be at least twice per year.																					
<input type="checkbox"/>	<b>Permanent or Long-Term Health Conditions</b> - 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"/>	<b>Health Conditions requiring Multiple Treatments</b> - (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"/>	<b>None of the above</b> - If none of the above five categories is checked, (i.e., inpatient care, continuing treatment includes but is not limited to examination to determine if a serious health condition exists and evaluation of the condition.), please still fill out the information in Section 2.																					

**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):**

**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

Other (please describe):

Form continues on next page

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

Patient's Name: \_\_\_\_\_ Patient's DOB: \_\_\_\_\_

Continued from previous page

**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 detail of the frequency of leave needed, and approximate duration per episode. Check all that apply.

<input type="checkbox"/> <b>Continuous Leave</b> My patient has/will be incapacitated for a single continuous period due to their own health condition, including time for treatment and recovery	<b>Start Date</b>	<b>End Date</b>	
<input type="checkbox"/> <b>Intermittent Leave</b> My patient is expected to have periodic flare-ups or follow-up treatment appointments where intermittent absence from work will be medically necessary	<b>Start Date</b>	<b>End Date</b>	<b>Incapacity</b> The Patient's incapacity may occur up to number of days per week.
<input type="checkbox"/> <b>Reduced Leave Schedule</b> My patient is expected to have a consistent but reduced work schedule for multiple weeks.	<b>Start Date</b>	<b>End Date</b>	<b>Frequency of Leave</b> (e.g. leave increment in days)

**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)	

**Certification and Signature**

**NOTICE** A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime."

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			

End of MN PFML – Medical Certification – Family 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)**

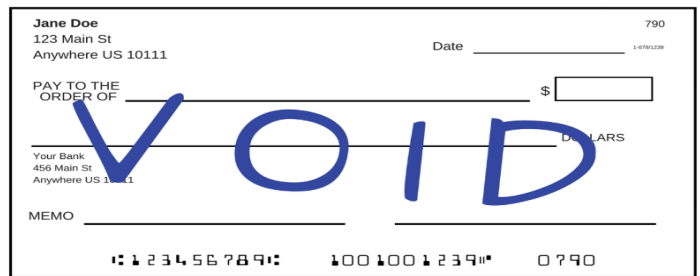
1. <b><u>Claimant Name (First name, Last name)</u></b>	2. <b><u>Social Security Number or I-TIN</u></b> (9 digits)
3. <b><u>ShelterPoint Life Claim Number(s)</u></b>	
4. <b><u>Account Type:</u></b> <input type="checkbox"/> Checking Account <input type="checkbox"/> Savings Account	

**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>
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