

## Minnesota Paid Family and Medical Leave (PFML)

### 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 vour submission. Email: 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 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 1st 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



# Minnesota Paid Family and Medical Leave (PFML)

### Checklist for Requesting Minnesota Paid Family and Medical Leave (MN PMFL)

Qualifying Leave Types (select one)
<b>NOTE:</b> 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
<ul> <li>Your health care provider completes the remainder of the MEDICAL CERTIFICATION –</li> </ul>
SELF CARE form and returns the completed form to you.
☐ Caring for a family member with a serious health condition
<ul> <li>☐ 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.</li> <li>☐ Complete the top portion of the MN - MEDICAL CERTIFICATION – FAMILY CARE form, providing information on yourself and your qualifying family member requiring care</li> <li>☐ Your family members health care provider completes the remainder of the MN - MEDICAL CERTIFICATION – FAMILY CARE form and returns the completed form to you.</li> </ul>
☐ 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



# Request for Minnesota Paid Family and Medical Leave (PFML)

Claim Number:

1

#### **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 30 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						
Demographic Information						
1. Claimant's Legal Name (First Name, Middle Initial, Last Name):						
First name Middle	e initial Last Name					
2. Claimant's Mailing Address (Street Address (including apt/fil#), 0						
Other thankling						
Street address						
City, State Zip	1. Oktobrillo Data (1. Data)					
3. Claimant's Social Security Number or I-TIN:	4. Claimant's Date of Birth:  5. Claimant's Gender:  Male					
	MONTH DAY YEAR ☐ Not Designated/Other					
6. Claimant's Primary Contact Phone Number & Type:	7. Claimant's Contact Email Address:					
area code						
$\square$ Mobile/Cellular Phone $\square$ Home Phone $\square$ Work Phone						
By providing your contact information, you consent	to Us contacting you by any of the methods provided.					
Leave Information	to 03 contacting you by any of the methods provided.					
8. Reason for PFML Request (choose ONE option):						
Medical leave due to <b>my own</b> serious health condition						
Bond with my new Child	Donal with an an an Obital					
Care for my Family Member with a serious health condition						
Safety Leave for myself or my family member due to domestic v	riolence, harassment, sexual assault, or stalking					
Qualifying Military Exigency						
9. Family Member's Relationship* to the Claimant is:						
* "Relationship" includes "biological, foster, adoptive, step, and in loco parentis r partner, if applicable.	elationships and the same relationships to the Claimant's spouse or domestic					
│ │ │ Self	☐ Child					
Spouse	☐ Grandparent					
☐ Domestic Partner	Grandchild					
☐ Parent	☐ Sibling					
	family relationship*, regardless of biological or legal relationship, based					
on the totality of the circumstances surrounding the relationship	· · ·					
I hereby assert that a family-like relationship exists between _	and(your name) and(name of person you have a family-like bond with)					
b. Describe how this relationship demonstrates a family relations	ship:					

Claimant Name:			_ Claimant SSN:				
Claimant Address:							
Leave Information (continued fro	Leave Information (continued from previous page)						
10. Leave Pattern and Period(s) Requester	d:						
Indicate whether leave will be taken continuo much detail as possible. <i>Any changes to you possible</i> .							
☐ Continuous Leave:		Leave Start		Leave End			
continuous uninterrupted period of leave for a sing qualifying reason.	de Ent	er the first date you are req leave from wo th day		Enter the last date you are red leave throug			
☐ Intermittent Leave:		Leave Start	Date <u>D</u>	ate(s)Requested:			
Leave in separate, non-consecutive time peri rather than a single span of time for a single qualify reason; episodic time off		Enter the first date you a	re requesting				
☐ Reduced Leave Schedule:		Leave Start Da	ate				
A consistent but reduced work schedule for multiple weeks	month	he first date you are reques  LEAVE from work.  day	year	Frequency of leave: number of days per we 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:	b. Date notice was provided to employer:						
c. If 30 day's advance notice was not provided, explain why:							
42 Other Types of Leave							
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 <b>Benefit Type</b>	received	claimed	from	through			
a. Unemployment benefits (CSEA)			(mm/dd/yyyy)		1		
b. Workers' Compensation							
·	_	_			<u></u>		
c. MN PFML							

Claimant Name:			Claimant SSN:_			
Claimant Address:						
<b>Employment Information</b>						
Provide information on your employment history outside of Minnesota.	istory in <b>Minnes</b>	ota. This inforr	nation will be verified wit	h your employer. Do not includ	de employment	
KEY TERMS: Benefit year: means the period except as provided in paragraphs					Section 268B.04	
Base period: The most recent for benefits , as outlined in Minnesota				current Employer before an en	nployee applies for	
Wages: means all compensation pay; vacation and holiday pay; ba and accounted for by the employe Statute Section 268.01 Subd. 29, provided to compensate an employed.	ack pay as of the ee to the employe and the cash val	date of paymeer; sickness and lue of housing,	ent; tips and gratuities pai d accident disability paym utilities, meals, exchange	id to an employee by a custon nents, except as otherwise pro es of services, and any other g	ner of an employer vided in Minnesota	
and hospitalization expenses, dis six calendar months from the emp is optional), reasonable and c reimbursements, payments made	<b>Wages does not include</b> : 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 4) quarters in which Wages were earned. Based of 0/01/2025-12/31/2025. The gross wages from the hig	on her start date, the	e lookback quarter	rs are 1. 01/01/2025 – 03/31/20	025 2. 04/1/2025 – 06/31/2025 3. 07/	1/2025 - 09/30/2025 4	
Sindy's highest quarter earnings during the base period ate under MN PFML.	d were in Q4 2025 wh	nen she earned \$14	4,000.00, making her AWW \$1,0	076.92. This AWW will be used to calc	ulate her weekly benefi	
3. Give the Name and Details of Your Fif you had more than one employer in the ooking back to the previous 4 calendar quand report that value in the "Gross Wages worked per week is based off your Regular	base period (the uarters prior in wh "column. You m	e last four cale hich you earne nay be asked t	d Wage credits , determin to provide supporting doc	ne the quarter in which your wa cumentation of wages. Averag	ages were highest ge hours and days	
Nost Recent Employer		,g		,		
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:	☐ Mo ☐ Tu ☐ We ☐ Th ☐ Fr☐ Sa☐ Su☐ Schedule Varies		
Other MN Employer(s)  f 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:	☐Mo ☐Tu ☐We ☐Th ☐Fr ☐ Sa ☐Su		
			Last Day Worked:	□ 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:	□ Mo □ Tu □ We □ Th □ Fr □ Sa □ Su		
				☐ Schedule Varies		

Claimant Name:	Claimant SSN:
Claimant Address:	
Benefit Payment Preferences	
Disclosure Statement: Information regarding PFML provided to the employer.	benefits received by the employee, such as payments received and leave schedule, will be
benefit recipient. If your claim does not qualify for A	g benefit payments. Certain options may not be available depending on the leave pattern or ACH/direct deposit, your benefit payments will automatically be issued via paper check. A e in direct deposit and proof of account information is required (e.g. a copy of a voided check the banking institution verifying account details).
<ul><li>□ Paper Check</li><li>□ Direct Deposit</li></ul>	
<del></del>	d or helps commit a fraud against an insurer is guilty of a crime." esota 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 beli	
Signature	Date Signed

End of MN PFML - Claimant Statement.



<del>,</del>	<del>_</del>
Employee's Legal Name:	Employee's SSN:
Employee's Mailing Address:	OON.
Employer Information (to be completed by	y the employer for the above named employee
requesting PFML)	y the employer for the above hamed employee
1. Business's full legal name and mailing address	
Business name (including any DBA or Trade Name)	
Street address	
City, State Zip	
2. Business's Federal Employer Identification Number	3. Employer contact person (Name & Title) for this leave request
-	
4. Employer's contact phone #	5. Employer contact email address
( ) Ext:	
6. Reason for PFML Request	
o. Reason for 11 Mc Request	
Medical leave due to employee's own serious health condition	
Bond with Child	
Care for Family Member with serious health condition*	
Safety Leave	
Qualifying Military Exigency  8. Provide the employee's earnings history for the prior 4	9. Usual work schedule, hours worked, and location of work
completed calendar quarters in which Wage credits were	or soud work someway, near of works, and results or work
earned Quarter Ending Gross Wages	weekly amount
(mm/yyyy) (\$)	Average # of days worked
(1)	per week, prior to the leave
	9a. request.  Average # of hours worked
	per week, prior to the leave
	9b. request.
	9c. Days of the week the employee usually works
	Mon Tues Wed Thur Fri Sat Sun
	9d. Address where the employee performs the majority of their work
	Street:
	City/St/Zip:)
	Gity/GuZip.)
Average	

Employer Statement 10/2025

Employee's Legal Name:	Employee's SSN:
Employee's Mailing Address:	1
Employer Statement continues on next page.	
Employer Information - Continued from previo	us page
10.Employee's Job Title/Description of duties	11. Employment status for the employee requesting leave
	Date employed:
	In active employment: Yes No
	Termination Date: mm/dd/yyyy
12. Will Leave be Utilized Continuously or Intermittently of to your leave plans and/or estimated dates must be communicated.	r on a Reduced Leave Schedule? Provide Details Below. Any changes cated/confirmed as soon as possible to us and your employer.
	ave Start Date  Leave End Date  rst date you are requesting  Enter the last date you are requesting continuous
	day year month day year
☐ Intermittent Leave:	Additional Leave Dates Requested Leave Start Date
Leave in separate, non-consecutive time periods rather than a single span of time for a single qualifying reason, Episodic time off	e first date you are requesting INTERMITTENT leave from work.    day
Enter the first da	Ave Start Date  The you are requesting REDUCED  EAVE from work.  Gray and requesting REDUCED  Frequency of leave: (Number of days per week. Be Specific
13. Was 30 days advance given to you by the employee re	questing foreseeable leave?
Yes Date notice provided to employer (mm/dd/yyyy)	
No Date notice provided to employer: (mm/dd/yyyy)	
Detail:	
	foreseeable leave?).
Yes No	
14. Has the employee received or claimed any of the follo supporting documentation pertaining to the type of benefit rec	wing benefits in the preceding 52 weeks? Provide detail below, and any
	aimed from through (mm/dd/yy) (mm/dd/yy)
a. Unemployment benefits	
b. Workers' Compensation	
c. MN PFML	
Other (Sick/Vacation/PTO or other employer provided	

d. leave. Please specify.)

Employer Statement continues on next page.

Employee's Mailing Address:	
Employer Information Continued from provious name	
Employer Information - Continued from previous page  15. Will the employee receive any wages or other benefits (see above) during any part of the	ne requested leave period?
	10 10quotou 10uvo ponou 1
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.	Yes No
a. Does the employee contribute to the cost of the MN Paid Medical leave (PML) coverage?	Skip a.l and go to Answer I. below question 17.b.
I If you what namentage of the averall MAN DMI magnitum does the	
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.	
<b>b.</b> Does the employee contribute to the cost of the MN Paid Family Leave (PFL) coverage?	
	Yes No
	Skip b.I and go to Answer I. below question 18.
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.	
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 insu	rer is guilty of a crime."
I am the person authorized to sign as the employer of the employee requesting benefits under the	
Leave Law. My signature affirms that to the best of my knowledge the information I have provided	
Signature	Date (mm/dd/yyyy)

Employee's SSN:

End of Employer Statement

Employee's Legal Name:



#### ShelterPoint Life Insurance Company

1225 Franklin Avenue, Ste. 475 Garden City, NY 11530 Fax: 516.504.6412 (main) | 516.504.6436 (service) | 516.504.6414 (claims) Phone: 800.365.4999 (516.829.8100) www.shelterpoint.com

#### HIPAA AUTHORIZATION FOR USE AND DISCLOSURE OF INFORMATION

**Instructions:** The individual who requires care completes this form, and provides a completed copy to their health care provider. For medical leave due to your own serious health condition, you may complete this form. 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 Nam	ne, Middle Initial, Last Name)			
Mailing address of Individual Receiving Care (Street Address (inc	cluding apt/fl #), City, State, Zip)			
Street address				
City, State Zip				
Care Recipient's Contact Phone #	Care Recipient's Date of Birth (mm/dd/yyyy)			
(				
2. Health Care Provider Information				
Name of Care Recipient's Health Care Provider (include full profe	essional designation, i.e. MD, DO)			
Mailing address of Health Care Provider (Street Address (including	ng 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 Prot	ected Health Information ("PHI") relating to my			
medical condition for which the medical certification	· · · · · · · · · · · · · · · · · · ·			
medical leave ("PFML") insurance carrier listed below.				
Carrier Name: SHELTERPOINT LIFE INSURANCE COMPANY				
Carrier Address: 1225 Franklin Avenue, Suite 475, Garden City NY 11530				
, , , , , , , , , , , , , , , , , , , ,	, caraon cu <b>,</b> co			
Unless I have put a check by the information that ma				
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)				
Signature of Care Recipient or Care Recip	pient's Legal Representative	Date signed (mm/dd/yyyy)		
If signed by Care Recipient's Legal Repre	sentative, complete the following:			
Printed Name of Care Recipient's Legal F	Representative:			
Relationship of Care Recipient to the Leg	al Representative:			
Please Check which of the following prov	ides authority to serve as a Legal representat	ive:		
Parental right;	Power of attorney (attach copy)			
Health care proxy (attach copy)	Court order (attach copy)			

End of HIPAA Authorization



### Request for Minnesota Paid Family and Medical Leave (PFML)

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 30days 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 N	lame):		
First name	Middle initial Last nam	9	
2. Claimant's Mailing Address (Street Address (including ap	pt/fl #), City, State, Zip):		
Street address			
City, State Zip			
3. Claimant's Social Security Number or TIN:	4. Claimant's Date of Bi	th: 5. Claimant's Gende	<u>r:</u>
	MONTH / DAY /	☐ Male ☐ Female ☐ Not Designated/O	ther
Family Member Information (covered family	member requiring	care due to their health c	ondition)
1. Family Member's Legal Name (First Name, Last Name):		2. Family Member's Date of Bir	th:
First Name Last Name		MONTH DAY	YEAR
3. Family Member's Mailing Address			
Street address			
City, State Zip			
4. The Family Member's Relationship* to Claimant:	ſ		
□ Child □ Spouse □ Domestic Partner □ Parent □ Grandparent □ G □ Person with whom the employee has a significant bond that is or is li	•	*Relationships include "biological, foste step, and in loco parentis relationships same relationships to the employee's s domestic partner, if applicable.	and the
MEDICAL CERTIFICATION (to be completed by	y the family membe	er's treating health care p	rovider)
A family member of your patient has made a request to be on their claim for MN Paid Family and Medical Leave ber information in this form. When completing this certification	nefits for the care of you		
<ul> <li>Your answers are to be your best estimate based</li> </ul>	d on your medical knowl	edge, experience, and examinat	ion of the

• 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).

Please note, health care providers may only certify the need for leave if such certification is within the

Be as specific as you can. Using terms like "as needed", "unknown" or "indeterminate" may not be enough to approve

diagnostic scope of their licensure, certification, or registration (Minnesota Statutes, sec. 268B.01, subdivision

**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.

patient.

the claim.

Cla	nimant Name: Claimant SSN:				
Pat	tient's Name: Patient's DOB:				
Contir	nued from prior page				
MED	ICAL CERTIFICATION	(to be completed by the family	/ member's treati	ng health care provider)	
1. Me	dical Information:				
a.	What was the <b>first date</b> on	which the patient's health condition com	menced?	month day / year	
b.	What is the probable duration	on of the health condition? (e.g., 3 month	ns; 2 weeks)		
C.	your belief that the health co	which your patient is requesting time awondition was caused by or otherwise rela	ated to a workplace	□ Yes □ No	
	Inpatient Care – The patient □was/□is/□will   dates:	(e.g., outpatient surgery, strep throat) ealth condition, the patient □is/□will be is/□will be seen on the following date(s):	ospital, hospice, or resi	idential medical care facility on the following below than seven consecutive, full calendar days.	
	care provider (e.g., p Chronic Health Conditions Permanent or Long-Term	□had/□has/□will also result(ed) in a prescription medication (other than over - (e.g., asthma, migraine headaches) ⊓ Health Conditions - Due to the health	course of continuing to the counter), therapy r reatment visits are exp condition, incapacity is	reatment under the supervision of a health requiring special equipment, etc.)  pected to be at least twice per year.  s permanent or long term and requires the	
	Health Conditions requirir	ealth care provider (even if active treath  g Multiple Treatments - (e.g., chemo  essary for the patient to receive multiple	otherapy treatments, re	ded). estorative surgery, etc.) Due to the health	
	condition, it is medically necessary for the patient to receive multiple treatments.  None of the above - 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.				
		relevant medical facts relating to the health of		ave (these facts may include diagnosis,	
	osis code(s):	g treatment such as the use of specialized eq	шртет).		
	& symptoms:				
Objec	tive findings:				
provide psycho	a brief description in the space logical comfort).	ualify for benefits, care of the patient must be below (e.g., assistance with basic medical, he ienic, nutritional, or safety needs □Physic	ygienic, nutritional, safety		

Claimant Name:		Claimant SSN:			
Patient's Name:		Patient's DOB:			
Continued from previous page					
MEDICAL CERTIFICATION - (	to be comp	leted by the famil	y member's treating h	nealth ca	re provider)
<b>4. Medical Leave Needed:</b> Indicate wheth schedule basis. If intermittent, provide detail					
Continuous Leave  My patient has/will be incapacitated for a s continuous period due to their own health including time for treatment and recovery		Start Date	End Date		
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 number of days per week.	
Reduced Leave Schedule  My patient is expected to have a consistent but reduced work schedule for multiple weeks.		Start Date	End Date		quency of Leave eave increment in days)
5. Health Care Provider Information: Ple for your files and return the original to the patient.	ease <b>print</b> all req	uested information legibly	 , then sign and date the form. F	Retain a cop	y of the completed form
Health Care Provider's First & Last Name:			Professional Designat	ion:	
Phone Number:			Specialty/Board Certifi	ication:	
Fax Number:			License Number and S	State:	
Business Address: (Practice name, Street address, City, State, Zip)			L		<u> </u>
Certification and Signature					
NOTICE A person who files a claim with inte	ent to defraud o	r helps commit a fraud	against an insurer is guilty o	of a crime."	
My signature certifies that the information pro accurately and to the best of my ability, the licensure, and that the patient is not one of r	at I am a healtl	n care provider authori			
Health Care Provider's Signature			Date Signed		
End of MN PFML – Medical Certification -	Family Care	orm	MONTH	/ DAY	/ YEAR



#### Direct Deposit Enrollment and Authorization Form for Minnesota Paid Family and Medical Leave (PFML) **Claims Payments**

#### **INSTRUCTIONS**

This form must be fully completed, signed, and dated to be valid. Incomplete, illegible or ineligible submissions are unable to be processed and will not be accepted.

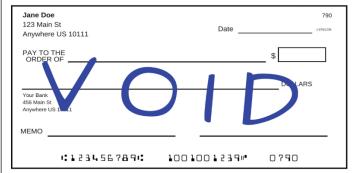
Eligibility for Direct Deposit: ShelterPoint Life Insurance Company ("Company") offers Direct Deposit Payments for Disability Benefits (DBL) and Paid Family Leave (PFL) claims where benefit payments are being issued directly to the claimant/employee. Direct deposit is not available if the Company is reimbursing your Employer due to their continued payment of wages. In the event that a direct deposit payment is rejected due to inaccurate banking information, the rejected payment and any future benefit payments due under the claim will be issued via paper check (and delivered via the USPS) until the bank information has been corrected and an updated Enrollment and Authorization Form submitted.

REQUIRED CLAIMANT INFORMATION (please print all information LEGIBLY)					
1. Claimant Name (First name, Last name)	2. Social Security Number or I-TIN (9 digits)				
3. ShelterPoint Life Claim Number(s)					
Account Type:     Checking Account					
ATTACH PROOF OF BANKING INFORMATION					
Examples of valid proof of banking include:	Jane Doe 790				

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 may result in direct deposit not being established under an approved claim.



#### SUBMITTING YOUR DIRECT DEPOSIT REQUEST

You must supply all information requested on this form. Fully completed, signed and dated forms may be sent to ShelterPoint by any one of the below listed methods:

Email: claimforms@shelterpoint.com

(516) 504-6414

ShelterPoint Life, Attn: Claims, 1225 Franklin Avenue, Suite 475, Garden City, NY 15530

If you have any questions regarding this form, please contact our Customer Service Department at 1-800-365-4999 during normal business hours. Please allow up to ten (10) business days for your direct deposit enrollment to be effective.

#### **AUTHORIZATION AND SIGNATURE**

I authorize ShelterPoint Life Insurance Company ("Company") to deposit any benefits I am eligible to receive directly into the bank account information that I have provided as an attachment to this form, 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. I acknowledge that if I am also covered under another ShelterPoint state-mandated benefit policy, this request will also apply to any other

EOBs and payment history via claims portal registration on shelterpoint.com.					
☐ Check this box if you <b>do not</b> want to receive paper EOBs in the mail if your direct deposit request is approved.					
Claimant Signature	Date (mm/dd/yyyy)				