

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)
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



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 my own serious health condition	
Bond with my new Child	
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	m 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:	month o	lay year]		
c. If 30 day's advance notice was not provided, explain why:					
42 Other Types of Leave					
Provide detail on other types of benefits/leav		sted in the preced	ing 52 weeks, and whe	ether it will extend throug	jh the current
requested leave period covered by this claim Benefit Type	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:					
Employment Information					
Provide information on your employment history outside of Minnesota.	istory in Minnes	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
Wages does not include: Paym and hospitalization expenses, dis six calendar months from the emp is optional), reasonable and c reimbursements, payments made employer-provided parking facilitie	sability payments ployee's last day ustomary directo by an employer	s, or death bend of work), the val or's fees for for a domestic	efits that are part of a pla alue of a special employe individuals who are no or agricultural employee	an for employees in general, see discount for goods or service ot otherwise employees, track's portion to Social Security ta	sick pay (paid after ses (if the purchase ovel and expense
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).
□ Paper Check□ Direct Deposit	
	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.



Employee's Legal Name:	Employee's
	SSN:
Employee's Mailing Address:	
Employer Information (to be completed by	the employer for the chave named employee
	the employer for the above named employee
requesting PFML) 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
(
area code	
6. Reason for PFML Request	
Medical leave due to empleyee's awa serious health	
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	
earned Quarter Ending Gross Wages	weekly amount
(mm/yyyy) (\$)	Average # of days worked
(**************************************	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/Gt/Zip./
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:
	mm/dd/yyyy
	In active employment: Yes No
	▼ Termination Date:
do Maria	mm/dd/yyyy
	or on a Reduced Leave Schedule? Provide Details Below. Any changes cated/confirmed as soon as possible to us and your employer.
☐ Continuous Leave:	eave Start Date
inter the f	irst date you are requesting Enter the last date you are requesting continuous leave from work. Enter the last date you are requesting continuous leave through
leave for a single qualifying reason	
month	day year month day year
☐ Intermittent Leave:	Leave Start Date he first date you are requesting INTERMITTENT
Leave in separate, non-consecutive time periods rather than a single span of time for a single qualifying reason, Episodic time off	leave from work.
, month	
Enter the first da	ave Start Date te you are requesting REDUCED Frequency of leave: (Number
A consistent but reduced work schedule for multiple weeks	of days per week. Be Specific)
13. Was 30 days advance given to you by the employee re	day year
To. Was oo days advance given to you by the employee	Squesting for escension leave.
Yes Date notice provided to employer (mm/dd/yyyy)	
Date notice provided to employer:	
No (mm/dd/yyyý)	
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 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
a. Unemployment benefits	(mm/dd/yy) (mm/dd/yy)
b. Workers' Compensation	
c. MN PFML	
Other (Sick/Vacation/PTO or other employer provided	

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
Does the employee contribute to the cost of the MN Paid Medical leave (PML) coverage?	Skip a.l and go to 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. 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:



Request for Minnesota Family and Medical Leave Insurance (MN PFML)

MILITARY EXIGENCY LEAVE ATTESTATION FORM

Military Exigency Leave allows a covered individual to take leave from employment based on a need arising out of the covered individual's family member's **active duty** service, or notice of an impending call or order to active duty in the armed forces. 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 7days after the start of the leave. Claim filing is the responsibility of the individual that is requesting paid leave benefits (the "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 or circumstances that would impact eligibility for benefits.

Demographic Information
1. Claimant's Legal Name (First Name, Middle Initial, Last Name)
First Name Middle Initial Last Name
2. Claimant's Mailing Address (Street Address (including apt/fl #), City, State, Zip)
Street address
City, State Zip
3. Claimant's Social Security Number or TIN 4. Claimant's Date of Birth Male
Female
Not Designated/Other
Service Member Details & Qualifying Exigency
1. Service Member's Legal Name (First Name, Middle Initial, Last Name)
First Name Middle Initial Last Name
2. Service Member's Mailing Address (Street Address (including apt/fl #), City, State, Zip)
Street address
City, State Zip
6. Service Member's Relationship to Employee (Claimant) Requesting Leave ☐ Child (of any age) ☐ Spouse ☐ Domestic Partner ☐ Parent ☐ Grandparent ☐ Grandchild ☐ Sibling ☐ In Laws
Others who are like family and depend on the employee
7. Current Service Member Affiliation
☐ Air Force ☐ Army ☐ Coast Guard ☐ Marine Corps ☐ Navy ☐ Reserves ☐ National Guard
8. Proof Documentation of Affiliation (proof documentation of service must be included with the claim, options are listed below)
□ Copy of Active-Duty Orders
☐ Letter of impending activation
☐ Letter from commanding officer or approving authority for service member's Rest and Recuperation
Other documentation reasonably acceptable in circumstances where the documentation specified above is unavailable.
9. Select Reason(s) for requesting leave (one or more reasons may be selected)
□Arranging for child care □Arranging for parental care □Counseling □Making financial arrangements □Making legal arrangements
□Spending time with the military member during a rest and recuperation leave or following return from deployment
☐ Attending any event sponsored by the military or military service organization
☐ Making arrangements following the death of the military member ☐ Other activity agreed to with your employer (provide detail)

Claimant Name:	Claimant SSN	I/I- I IN:
Claimant Address:		
Service Member Details & Qualifying	ng Exigency (Continued from pric	or page)
10. Date(s) or period of time for which lea	ve is requested:	
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.	Leave End Date Enter the last date you are requesting continuous leave through. March Ma
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. mont day year	Date(s) & Hour(s) Requested:
☐ Reduce 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)
Attestation and Signature		
NOTICE A person who files a claim with intent to defra I am hereby making a request for benefits under the Min providing is true and accurate to the best of my knowled	nnesota Family and Medical Leave Insurance program	
Signature		Date Signed
		month day year

End of MN – PFML - Military Exigency Leave Attestation form



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.

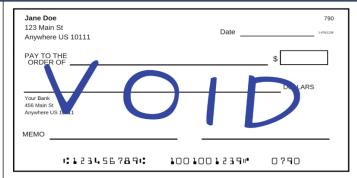
Eligibility for Direct Deposit: ShelterPoint Life Insurance Company ("Company") offers Direct Deposit Payments for Disability Benefits (DBL) and Paid Family Leave (PFL) claims where benefit payments are being issued directly to the claimant/employee. Direct deposit is not available if the Company is 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. <u>Social Security Number or I-TIN</u> (9 digits)		
3. ShelterPoint Life Claim Number(s)			
4. Account Type: Checking Account	Savings Account		
ATTACH PROOF OF BANKING 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 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

• Fax: (516) 504-6414

Mail: 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 current open claim(s) that are eligible for direct deposit, if approved by the Company. I understand that I have the opportunity to view my EOBs and payment history via claims portal registration on shelterpoint.com.

EOBs and payment history via claims portal registration on shelterpoint.com.			
☐ 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)			