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
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*

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

SHELTERPOINT
ShelterPoint Life Insurance Company

Request for Minnesota Paid Family and Medical Leave (PFML)

Claim Number:

CLAIMANT STATEMENT

This Application ("Claimant Statement") is completed by the individual that is requesting paid leave benefits (the "Claimant" 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 or incomplete information may delay processing.

Demographic Information

1. Claimant's Legal Name (First Name, Middle Initial, Last Name):

First name | *Middle initial* | *Last Name*

2. Claimant's Mailing Address (Street Address (including apt/fl #), City, State, Zip):

Street address

City, State Zip

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

☐☐☐ - ☐☐ - ☐☐☐☐

4. Claimant's Date of Birth:

☐☐ / ☐☐ / ☐☐☐☐

MONTH DAY YEAR

5. Claimant's Gender:

☐ Male
☐ Female
☐ Not Designated/Other

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

(☐☐☐) ☐☐☐ - ☐☐☐☐

area code

☐ Mobile/Cellular Phone ☐ Home Phone ☐ Work Phone

7. Claimant's Contact Email Address:

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

Leave Information

8. Reason for PFML Request (choose ONE option):

☐	Medical leave due to **my own** serious health condition
☐	Bond with my new Child
☐	Care for my Family Member with a serious health condition
☐	Safety Leave for myself or my family member due to domestic violence, 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 relationships and the same relationships to the Claimant's spouse or domestic partner, if applicable.

☐	Self	☐	Child
☐	Spouse	☐	Grandparent
☐	Domestic Partner	☐	Grandchild
☐	Parent	☐	Sibling

☐ Individual who has a *significant personal bond* that is or is *like a family relationship**, regardless of biological or legal relationship, based on the totality of the circumstances surrounding the relationship (***affirm & provide detail in a. and b. below)***

a. I hereby assert that a family-like relationship exists between _____ (your name) and _____ (name of person you have a family-like bond with)

b. Describe how this relationship demonstrates a family relationship: _____

_____

_____

_____

_____

Form continues on next page

Claimant Name: _____ Claimant SSN:_____

Claimant Address: _____

Leave Information (continued from previous page)

10. Leave Pattern and Period(s) Requested:

Indicate whether leave will be taken continuously (all at once), 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 (mm/dd/yyyy)	through (mm/dd/yyyy)
a.	Unemployment benefits (CSEA)	☐	☐		-
b.	Workers' Compensation	☐	☐		-
c.	MN PFML	☐	☐		-

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:	☐Mo ☐Tu ☐We ☐Th ☐Fr ☐Sa ☐Su - - - - - - - - - - - - - - - - - ☐ 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 ($) Wages in Base Period
			Hire Date: Last Day Worked:	☐Mo ☐Tu ☐We ☐Th ☐Fr ☐Sa ☐Su - - - - - - - - - - - - - - - - - ☐ Schedule Varies	
Business Name, Address/City/St/Zip, Tax ID #	**Avg # hours/week** (e.g. 40 hrs/wk)	**Avg # days/week** (e.g. 5 days/wk)	**Employment date(s)** (MM/DD/YYYY)	**Days of the Week usually worked:**	**Gross ($) Wages in Base Period**
			Hire Date: Last Day Worked:	☐Mo ☐Tu ☐We ☐Th ☐Fr ☐Sa ☐Su - - - - - - - - - - - - - - - - - ☐ Schedule Varies	

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.

Request for Minnesota Paid Family and Medical Leave (PFML)

ShelterPoint Life Insurance Company

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

Employer Information (to be completed by 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 #

(☐☐☐) ☐☐☐ - ☐☐☐☐ Ext: _____

area code

5. Employer contact email address

6. Reason for PFML 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 completed calendar quarters in which Wage credits were earned

Quarter Ending (mm/yyyy)	Gross Wages ($)
Average	**$ 0.00**

9. Usual work schedule, hours worked, and location of work

		weekly amount
9a.	Average # of days worked per week, prior to the leave request.	
9b.	Average # of hours worked per week, prior to the leave 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:)_____

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

Employer Statement continues on next page.

Employer Information - Continued from previous 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: _____
mm/dd/yyyy

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.
__ __ / __ __ / __ __ __ __
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

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.
__ __ / __ __ / __ __ __ __
month / day / year

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	☐	☐		-
b.	Workers' Compensation	☐	☐		-
c.	MN PFML	☐	☐		-
d.	Other (Sick/Vacation/PTO or other employer provided leave. Please specify.)	☐	☐		-

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?

☐ **Yes** (Answer l. below) ☐ **No** (Skip a.l and go to question **17.b**.)

l. 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** (Answer l. below) ☐ **No** (Skip b.l and go to question **18**.)

l. 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 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.

Signature	**Date** (mm/dd/yyyy)

End of Employer Statement

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 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 #

( ) -

area code

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

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)

Signature of Care Recipient or Care Recipient's Legal Representative	**Date signed** *(mm/dd/yyyy)*

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:

☐ Parental right;
☐ Power of attorney (attach copy)
☐ Health care proxy (attach copy)
☐ Court order (attach copy)

End of HIPAA Authorization

ShelterPoint Life Insurance Company

Request for Minnesota Paid Family and Medical Leave (PFML)

Claim Number:

MINNESOTA MEDICAL LEAVE CERTIFICATION - SELF CARE

Medical Leave – **Self Care** allows an eligible individual to take leave from employment to attend to their own 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

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Claimant Information (to be completed by the Claimant requesting medical 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:

☐☐☐ - ☐☐ - ☐☐☐☐

4. Claimant's Date of Birth:

☐☐ / ☐☐ / ☐☐☐☐

MONTH DAY YEAR

5. Claimant's Gender:

☐ Male
☐ Female
☐ Not Designated/Other

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

Instructions: Please print information legibly and answer all questions fully and completely. When providing information surrounding the length/duration of a condition, or the frequency of treatment, be specific. Dates are intended to be best estimates based upon the medical facts for this patient, and in alignment with general guidelines. **Do not use terms such as "unknown, lifetime, indeterminate"**, as this will delay the patient's claim process and the answers will be deemed incomplete. After completing this form, return it to the Patient. Do not provide 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 Claimant's family members, 29 C.F.R. § 1635.3(b).

Definitions & Examples:

(a) A "**Serious health condition**" means a physical or mental illness, injury impairment, condition, or substance use disorder that involves:

(1) **Inpatient care** in a hospital, hospice, or residential medical care facility, including any period of incapacity; or
(2) **Continuing treatment or supervision by a health care provider** which includes any one or more of the following
  (i) A period of incapacity of seven or more days, and any subsequent treatment or period of incapacity relating to the same condition, that also involves:
    (A) Treatment two or more times, within 30 days of the first day of incapacity, unless extenuating circumstances beyond the individual's control prevent a follow-up visit from occurring as planned, by a health care provider or by a provider of health care services under orders of, or on referral by, a health care provider; or
    (B) Treatment by a health care provider or on at least one occasion that results in a regimen of continuing treatment under the supervision of the health care provider;
  (ii) A period of incapacity due to medical care related to pregnancy;
  (iii) A period of incapacity or treatment for a chronic health condition that:
    (A) Requires periodic visits, defined as at least twice a year, for treatment by a health care provider or under orders of, or on referral by, a health care provider;
    (B) Continues over a extended period of time, including recurring episodes of a single underlying condition; and
    (C) May cause episodic rather than continuing periods of incapacity;
  (iv) A period of incapacity which is permanent or long term due to a condition for which treatment may not be effective. The applicant or family member must be under the continuing supervision of, but need not be receiving active treatment by, a health care provider; or
  (v) A period of absence to receive multiple treatments, including any period of recovery from the treatments, by a health care provider or by a provider of health care services under orders of, or on referral by, a health care provider, for:
    (A) A restorative surgery after an accident or other injury; or
    (B) A condition that would likely result in a period of incapacity of more than seven full calendar days in the absence of medical intervention or treatment.

(a) For the purposes of paragraph (a), clauses (1) and (2), treatment by a health care provider means an in-person visit or telemedicine visit with a health care provider, or by a provider of health care services under orders of, or on referral by, a health care provider.
(b) For the purposes of paragraph (a), treatment includes but is not limited to examination to determine if a serious health condition exists and evaluations of the condition.
(c) Absences attributable to incapacity under paragraph (a), clauses (2), item (ii) or (iii), qualify for leave under this chapter even if the applicant or the family member does not receive treatment from a health care provider during the absence, and even if the absence does not last more than seven consecutive, full calendar days.

Form continues on next page

Claimant Name: _____ Claimant SSN:_____

Claimant Address: _____

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

1. Medical Information:

a.	Does the Patient have a **serious health condition**? See **page 1** for definitions	☐ Yes ☐ No
b.	What was the first date on which the patient's serious health condition commenced?	*(mm/dd/yyyy)*
c.	What is the probable duration of the serious health condition? (eg: 3 months, 2 weeks)	
d.	Is the serious health condition job-related?	☐ Yes ☐ No
e.	Is the serious health condition pregnancy related? (If yes, complete Pregnancy section)	☐ Yes ☐ No
f.	Is the serious health condition related to organ, tissue, or bone marrow donation?	☐ Yes ☐ No
g	Which of the following apply to the patient's serious health condition? Check all that apply	

☐ Requires, or did require **inpatient care**

☐ Has incapacitated or will incapacitate the patient for more than 7 consecutive full calendar days

☐ Requires 2 or more medical visits

☐ Requires 1 medical visit plus a regimen of care

☐ Is chronic, requires treatments, and may require periodic absences

☐ Is long-term and requires ongoing medical supervision, with or without active treatment

☐ Requires multiple treatments and would lead to a period of incapacity without treatment

☐ Is terminal

2. Diagnosis/Analysis: Diagnosis code(s):

Signs & symptoms:

Objective findings:

3. Treatment & Care: All questions must be completed. Missing or incomplete answers will delay processing of the claim. **Do not list dates as "TBD", "Unknown" or "Lifetime".**

		Date *(mm/dd/yyyy)*
a	First date of treatment (list the first date the patient received treatment or was seen by you for this serious health condition)	
b	Most recent date of treatment (the most recent date the patient was seen for this serious health condition)	
c	Date patient was unable to work because of this serious health condition (date patient deemed unable to perform their job duties due to their serious health condition)	
d	Date patient will be able to return to work (estimated date the patient may return to work. This is not the FMLA end date but the date the patient is medically capable of working).	

4. Pregnancy-related Serious Health Condition:

		Date *(mm/dd/yyyy)*
a	Estimated delivery date:	
b	Actual delivery date:	
c	Delivery type (select one if known)	☐Vaginal ☐C-Section
d	Antepartum complications, if any:	
e	Postpartum complications, if any:	
f	Does the patient have any limitations related to pregnancy, childbirth, or related medical condition, including but not limited to lactation? ☐Yes ☐No	

Form continues on next page

Claimant Name: _____ Claimant SSN:_____

Claimant Address: _____

MEDICAL CERTIFICATION (continued from previous page)

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

		Start Date *(mm/dd/yyyy)*	End Date *(mm/dd/yyyy)*
a	☐ Continuous Leave *Completely unable to work for consecutive, uninterrupted days.*		
b	☐ Intermittent Leave/Reduced Leave Schedule *Intermittent leave is leave in separate, non-consecutive time periods rather than a single span of time for a single qualifying reason. Episodic time off. Reduced leave is a consistent but reduced work schedule for multiple weeks. (e.g. number of days per week. Be specific).*	Start Date *(mm/dd/yyyy)*	End Date *(mm/dd/yyyy)*

	Freq. of Episode	# times	Per Week	Per Month	Per Year
Frequency of leave required for flare-ups or treatments relating to this serious health condition *(e.g. 1 episode every 3 months lasting 1-2 days)*					
Length of episode:			# Full day(s) *(minimum leave increment is 1 day)*		

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

Provider Type: ☐ **DC** ☐ **MD** ☐ **DO** ☐ **CNM** ☐ **DDS/DMD** ☐**OD** ☐**PA** ☐**PSY D** ☐**RN** ☐ **CSW** ☐**Spiritual provider** (e.g. Christian Science Practitioner)

Provider's First & Last Name:		Professional Designation (Ex: MD, DO, PA, CNM)	
Phone #:		License State:	
Fax #:		License #:	
Mailing Address: (Practice name, Street address, City, State, Zip)			

Certification and Signature

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

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My signature attests 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, and that I am a health care provider authorized to certify their condition.

Health Care Provider's Signature	**Date Signed**
	☐☐ / ☐☐ / ☐☐☐☐ MONTH DAY YEAR

End of MN PFML - Medical Certification- Self Care 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)

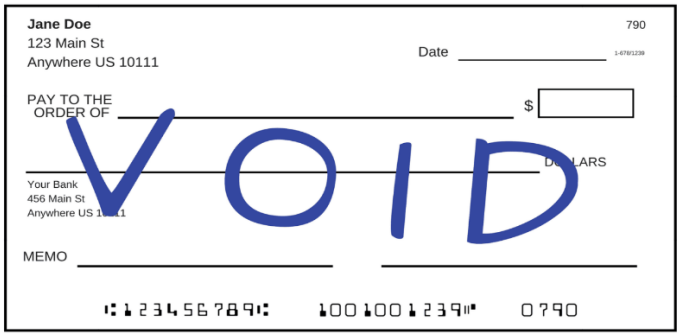
1. **Claimant Name (First name, Last name)**
2. **Social Security Number or I-TIN** (9 digits)
3. **ShelterPoint Life Claim Number(s)**
4. **Account Type:** ☐ Checking Account ☐ Savings Account

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.

☐ 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)**