ShelterPoint
ShelterPoint Life Insurance Company

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 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*

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

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.

SHELTERPOINT
ShelterPoint Life Insurance Company

Request for Minnesota Paid Family and Medical Leave (PFML)

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	

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 I. below ☐ **No** — Skip a.I and go to question **17.b**.

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** — Answer I. below ☐ **No** — Skip b.I and go to 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 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
ShelterPoint Life Insurance Company

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

Claim number:

MINNESOTA SAFETY LEAVE ATTESTATION FORM

Safety 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:

(a) seek medical attention related to the physical or psychological injury or disability caused by domestic abuse, sexual assault, or stalking;

(b) obtain services from a victim services organization;

(c) obtain psychological or other counseling;

(d) seek relocation due to the domestic abuse, sexual assault, or stalking; or

(e) seek legal advice or take legal action, including preparing for or participating in any civil or criminal legal proceeding related to, or resulting from, the domestic abuse, sexual assault, or stalking.

CLEARLY IN BLUE OR BLACK INK. Missing or incomplete information may delay processing.

Claimant Information (to be completed by the individual requesting Safety 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: (9 digits)	4. Claimant's Date of Birth:	5. Claimant's Gender
☐☐☐ - ☐☐ - ☐☐☐☐	☐☐ / ☐☐ / ☐☐☐☐ (month / day / year)	☐ Male ☐ Female ☐ Not Designated/Other

6. Reason for Safety Leave Request: (one or more options may be selected).

☐ **Safety Leave to care for my Family Member**

Select type of care provided:
- ☐ Seek medical care for my Family Member, (including counseling) for physical or psychological injury or disability or to aid in recovery from injuries caused by domestic abuse, sexual assault, harassment, or stalking.
- ☐ Obtain services for my Family Member from a victim services organization
- ☐ Obtain psychological or other counseling for my Family Member
- ☐ Relocate my Family Member
- ☐ Seek legal advice or take legal action, including preparing for or participating in any civil or criminal legal proceeding related to or resulting from, the domestic abuse, sexual assault, or stalking.

☐ Safety Leave **for myself** to seek **medical care** (including counseling) for physical or psychological injury or disability **or** to **recover from injuries** caused by domestic abuse, sexual assault, harassment, or stalking

☐ Safety Leave **for myself** to
- ☐ Obtain services from a victim services organization
- ☐ Obtain psychological or other counseling
- ☐ Seek relocation due to the domestic abuse, sexual assault, or stalking
- ☐ Seek legal advice or take legal action, including preparing for or participating in any civil or criminal legal proceeding related to, or resulting from, the domestic abuse, sexual assault, or stalking.

Form continues on next page

Claimant Name: ______________________________________ Claimant SSN:_______________

Claimant Address: ____

Safety Leave Required Documentation

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 attest that I am in need of Safety Leave due to myself or my family member being the victim of domestic abuse, stalking, or sexual assault or abuse. I am hereby making a request for benefits under Minnesota Paid Family and Medical Leave Insurance. 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

Qualified Person Certification (to be completed by the qualified person)

I attest I am

☐ an Attorney acting in their professional capacity;

☐ A licensed, certified, or otherwise authorized under law to practice as a mental health professional or practitioner as defined by Minn. Stat. 245I.04;

☐ licensed health care professional

☐ Domestic abuse advocate/ Sexual assault counselor as defined by Minn.Stat 595.02; acting in their professional capacity

☐ Victim's advocate employed, contracted, or appointed by the court acting in their professional capacity;

☐ judge, appointed referee, court administrator, prosecutor, or probation officer;

☐ Title IX coordinator, as defined by C.F.R. ch. 34 §106.8;

☐ A peace officer, part-time peace office, or reserve officer as defined by Minn. Stat. § 626.84; or

☐ Any other person acting in their professional capacity who can submit documentation that includes the necessary information required by Minn. Stat. § 268B.06.

abuse

Qualified Person's First and Last Name	Organization Name
Professional Designation (e.g. M.D. DO, P.A, CNM, Esq)	**Speciality/Certifications**
License/Certification Number and State:	**Phone Number and Fax Number:**
Business Address: (Business Name, Street address, City, State, Zip)	**Date Signed** ☐☐ / ☐☐ / ☐☐☐☐ month day year

End of MN PFML - Safety Leave Attestation form

SHELTERPOINT

Direct Deposit Enrollment and Authorization Form

INSTRUCTIONS

PLEASE PRINT ALL INFORMATION CLEARLY IN BLUE OR BLACK INK. This form must be fully completed, signed, and dated to be valid. Ineligible or incomplete submissions are unable to be processed and will not be accepted.

Eligibility for Direct Deposit: ShelterPoint Life Insurance Company (SPL) and ShelterPoint Insurance Company (SPI) (collectively, the "Companies" and each, a "Company") each offer direct deposit for statutory claim payments. A Company shall be legally recognized and deemed an active party to this agreement in jurisdictions where their involvement is required or legally recognized with all associated rights and obligations. Each Company is independent with respect to the other and is solely responsible for its own performance and neither Company shall have any authority to bind the other or incur obligations on the other's behalf.

Direct deposit, for statutory claim payments, is only available where benefit payments are being issued directly to a claimant/employee. Direct deposit is **not** available if statutory benefits are being issued to an Employer.

In the event that a direct deposit payment is rejected by a bank, the rejected payment and any future benefit payments due under the claim will be issued via check until the bank information is corrected and an updated Enrollment and Authorization Form is submitted.

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

- Upload your completed form via www.shelterpoint.com
- Email to: claimforms@shelterpoint.com
- Fax to: 516-504-6414
- Mail to: ShelterPoint, 1225 Franklin Avenue - Suite 475, Garden City NY 11530

If you have any questions regarding this form, contact our Customer Service Department at 1-800-365-4999.

Please allow up to 10 business days for set up of your direct deposit request.

REQUIRED INFORMATION (please print all information CLEARLY)

1. **Claimant Name (First name, Last name)**

2. **Social Security Number or I-TIN** (9 digits)

3. **ShelterPoint Life Claim Number(s)**

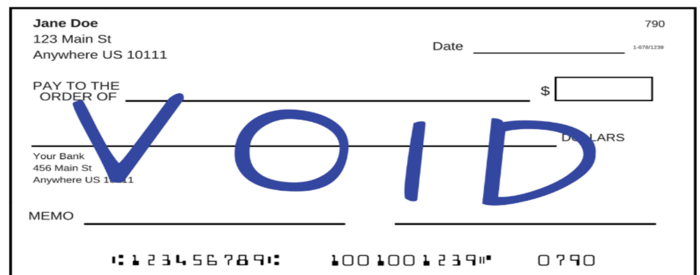
4. **Account Type:** ☐ Checking Account ☐ Savings Account

ATTACH PROOF OF BANK ACCOUNT INFORMATION

Examples of valid proof of banking include:

- A copy of a voided check with your name, address, bank name, routing number and account number listed; or
- A written statement from your bank confirming account holder name, address, bank name, routing number and account number

Failure to include proof of banking information will result in direct deposit not being established under an approved claim.



AUTHORIZATION AND SIGNATURE

I authorize the applicable Company to deposit any benefits I am eligible to receive directly into the bank and account indicated or to such other account as the bank or any successor bank designates as my account. I also authorize the applicable Company to debit my account for any deposits made in error, or the Company reserves the right to request the return of such funds through other mechanisms. I also understand that my successful direct deposit enrollment will stay in effect until I notify the Company, in writing, of cancellation or until I am no longer eligible for or due payments, whichever comes first. Lastly, should I become eligible for claim payments under multiple, separate and distinct claims, my successfully enrollment shall apply to all approved claims.

☐ Check this box if you **do not** want to receive paper EOBs in the mail if your direct deposit request is approved.

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