TheStandard®

Standard Insurance Company
866.756.8116 Tel 866.751.5174 Fax
PO Box 3877 Portland OR 97208

Applying For Connecticut Paid Family And Medical Leave (CT PFML)

To Use Connecticut Paid Family And Medical Leave For: Your own serious health condition

Complete Form CT PFML-1
- ☐ Complete CT PFML-1, Part A
- ☐ Provide CT PFML-1 to employer
- ☐ Employer completes CT PFML-1, Part B and returns to you within 3 days

Complete Form CT PFML-6
- ☐ Complete CT PFML-6 and give to health care provider
- ☐ Health care provider keeps CT PFML-6

Complete Form CT PFML-7
- ☐ Complete “Employee” information at the top of CT PFML-7
- ☐ Provide CT PFML-7 to your healthcare provider
- ☐ Health care provider completes CT PFML-7 and returns to you

Send forms and documents
- ☐ Send completed forms and supporting documentation to The Standard
- ☐ The Standard accepts or denies claim within 5 days once a complete claim is received

Please keep a copy of all pages for your records.

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Request For Connecticut Paid Family And Medical Leave (Form CT PFML-1) Instructions

- To request Connecticut Paid Family And Medical Leave (CT PFML), the employee requesting CT PFML must complete Part A of the *Request For Connecticut Paid Family And Medical Leave* (Form CT PFML-1). All items on the form are required unless noted as optional. The employee then provides the form to the employer to complete Part B.
- The employer completes Part B of the *Request For Connecticut Paid Family And Medical Leave* (Form CT PFML-1) and returns it to the employee within three days.
- Additional forms are required depending on the type of leave being requested. The employee requesting leave is responsible for the completion of these forms.
- The employee submits the completed *Request For Connecticut Paid Family And Medical Leave* (Form CT PFML-1) with the required additional form to The Standard. The employee should retain a copy of each submitted form for their records.

PART A - EMPLOYEE INFORMATION (to be completed by the employee)

The employee requesting CT PFML must complete all required information.

Connecticut Paid Family And Medical Leave (CT PFML) Request (to be completed by the employee)

Question 10: Family member means an employee's spouse, sibling, son or daughter, grandparent, grandchild, parent (includes parent-in-law), or an individual related to the employee by blood or affinity whose close association the employee shows to be the equivalent of those family relationship.
Child means a biological, adopted or foster child, a stepchild or legal ward, a child to whom the employee stands in *loco parentis*.
Grandchild means a child of the employee's child.
Grandparent means a parent of the employee's parent.
Parent means the biological, parent-in-law, adoptive, step-brother or step-sister of the employee.
Spouse means a husband or wife or domestic partner of an employee.
Family Member Equivalent: an individual related to the employee by blood or affinity whose close association the employee shows to be the equivalent of those family relationship.

Question 11: If dates are "Continuous", the employee must provide the start and end dates of the requested CT PFML. These dates should be the actual dates that the CT PFML will begin and end. If uncertain, estimate the start and end dates and indicate "Dates are estimated". If dates are "Periodic", enter the dates CT PFML will be taken. Please be as specific as possible. If the dates are unknown or estimated, indicate "Dates are estimated".

If dates are estimated, The Standard may require you to submit a request for payment after the CT PFML day is taken. Payment for approved claims will be due 15 calendar days from the date of the claim decision.

Question 12: Date employer was notified. If the employee is submitting the CT PFML request to their employer with less than 30 days' advance notice from the start date of the CT PFML, the employee must explain why 30 days' notice could not be given. If the explanation will not fit in the space provided on the form, enter "See Attached" and add an attachment with the explanation. Be sure to include the employee's full name and their date of birth at the top of the attachment.

Employment Information (to be completed by the employee)

Question 14: Enter the date of hire to the best of the employee's recollection. If it has been more than a year since the date of hire, entering the year in which employment started is sufficient.

Question 19: List all other income you will be receiving while on CT PFML. Include the type/name of income and how much. Example PTO from employer for $500.00 a week.

If you are pre-submitting form: Indicate if the employee is pre-submitting their CT PFML request. Pre-submitting is defined as submitting the application in advance of an upcoming qualifying event, with certain required information missing due to the information being unknown at the time of the submitting. If pre-submitting is permitted by The Standard, the missing information must be supplied as soon as it is known. Benefits cannot be determined until all of the required information is provided.

The Standard will provide the employee a notice within five days which 1) states the claim is pending; 2) identifies what information is missing; 3) instructs how to submit the missing information. **Payment for approved claims will be due 15 calendar days from the date of the claim decision.**

If The Standard does not permit pre-submitting, The Standard must return the Request for Connecticut Paid Family And Medical Leave within five days to the employee with an explanation that the claim should be re-submitted when all information is available.

Employee signs and dates, before giving this form to their employer to complete Part B.

PART B - EMPLOYER INFORMATION (to be completed by the employer)

The employer of the employee requesting CT PFML must complete all information in Part B.

Question 2: If a Social Security Number is used for the Federal Employer Identification Number (FEIN), enter the Social Security Number.

“Wage” or “wages”: For the purpose of payment of benefits, means a Covered Employee’s remuneration from the Employer for employment and dismissal payments.

Weekly Wages: means an amount equal to one twenty sixth, rounded to the next lower dollar, of a Covered Employee’s Total Wages, as defined in subsection (b) of Section 31-222 of the general statutes, or self-employment income, as defined in 26 USC 1402(b), as amended from time to time, earned during the two quarters of the Covered Employee’s base period in which such earnings were highest.

Employer signs and dates, and then returns to the employee requesting CT PFML within three business days.

Be sure to complete the appropriate additional CT PFML form(s) based on the type of CT PFML leave being requested.

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Request For Connecticut Paid Family And Medical Leave (Form CT PFML-1)

TO BE COMPLETED BY THE EMPLOYEE

Employee's name (first name, middle initial, last name)	Employee's date of birth (MM/DD/YYYY)

PART A - EMPLOYEE INFORMATION (to be completed by the employee)

1. Employee's legal name (first name, middle initial, last name)
2. Other last names, if any, under which employee has worked
3. Employee's mailing address Street | City | State | Zip Code | Country (if not USA)
4. Employee's Social Security Number or TIN
5. Employee's date of birth (MM/DD/YYYY)
6. Employee's primary telephone number ( )
7. Employee's preferred email address while on CT PFML (if available)
8. Employee's gender ☐ Male ☐ Female ☐ Not designated/Other
9. Reason for CT PFML request:
   - ☐ Bond with child ☐ Adoption/Foster child ☐ Care for family member ☐ Employee Impacted by Family Violence
   - ☐ Military qualifying event ☐ Military Caregiver: Care of a family member injured in the line of duty
   - ☐ Own serious health condition due to Covered Employee serving as a Bone Marrow Donor
   - ☐ Own serious health condition due to Covered Employee serving as an Organ Donor
   - ☐ Own serious health condition due to pregnancy ☐ Own serious health condition (other)
10. The family member is employee's: ☐ Child ☐ Spouse or registered domestic partner ☐ Family Member Equivalent ☐ Sibling ☐ Parents and legal guardians (or spouse's parent) ☐ Grandparent ☐ Grandchild
11. Will CT PFML be for a continuous period of time and/or periodic?

☐ Continuous ______ / ________ / __________ (CT PFML start date (MM/DD/YYYY)) __________ / ________ / _________ (CT PFML end date (MM/DD/YYYY)) ☐ Dates are estimated

Identify dates periodic CT PFML will be taken:

☐ Periodic ____ ☐ Dates are estimated

12. Date employer was notified. If providing less than 30 day's advance notice to the employer, please explain:

Employment Information (to be completed by the employee)

13. Business name
14. Employee's date of hire (MM/DD/YYYY)

14a. Employee's last day of work (MM/DD/YYYY)

15. Has your employment ended? If so, what was your termination date?
16. Employee's work location Street address

City | State | Zip code | Country (if not U.S.A.)

17. Employer's telephone number for contact regarding this request. ( )
18. Is employee currently receiving Workers' Compensation Benefits? ☐ Yes ☐ No
19. List income you will be receiving while on CT PFML, source of pay and amount.
20. Have you taken any leave in the last 12 months? ☐ Yes ☐ No
21. If yes list dates and type of leave.

Disclosure statement: Information regarding CT PFML benefits received by the employee, such as payments received and types of leave, will be provided to the employer.

Declaration and signature

Under penalties of perjury, I declare that to the best of my knowledge and belief, the information contained herein is true, correct, and complete. Any false statements or other failure to provide truthful, accurate and complete information may result in monetary and other penalties as well as the possibility of criminal prosecution.

Employee's signature	Date signed (MM/DD/YYYY)

☐ I am submitting this form in advance (see instructions about pre-submitting). I understand the insurance carrier will contact me to advise how to submit the required missing information.

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Request For Connecticut Paid Family And Medical Leave (Form CT PFML-1)

TO BE COMPLETED BY THE EMPLOYEE

Employee's name (first name, middle initial, last name)	Employee's date of birth (MM/DD/YYYY)

PART B - EMPLOYER INFORMATION (to be completed by the employer)

1. Business's full legal name and mailing address

Mailing address

City	State	Zip code	Country (if not U.S.A.)

2. Employer's FEIN

3. Employer's EIN	4. Employer's contact name for questions related to CT PFML

5. Employer's contact telephone number ( )	6. Employer's contact email address

7. Employee's date of hire (MM/DD/YYYY)	7a. Employee's last day of work (MM/DD/YYYY)

8. Employee's Weekly Wages

9. Employee's Typical Work Week Hours

10a. Check Days Normally Worked ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday ☐ Sunday

10b. Is employee hourly or salaried? ☐ Hourly ☐ Salaried

11. List the last date the employee will receive pay, for example the last date through which sick leave benefits, if any, will be paid.

12. Will any full days of accrued paid time* be used in place of PFML benefits? ☐ Yes ☐ No
If so, please provide dates where full days of accrued paid time is being used. ____________________
**Accrued paid time could be sick leave, annual leave, vacation leave, personal leave, compensatory leave or paid time off.*
Use of full days of accrued paid time, in place of PFML benefits, will not decrement the employee's PFML bank.

13a. What type of paid benefits will the employee receive while on CT PFML? Include the last date through which any compensation will be paid.

13b. Is the leave request a result of employee's injury on the job? ☐ Yes ☐ No
If yes, has the employee applied for Worker's Compensation payments/benefits? ☐ Yes ☐ No
If yes, has the employee received Worker's Compensation payments/benefits? ☐ Yes ☐ No
Amount of Weekly Payment/Benefit: $________________ Effective date of benefits: ____________________

14. CT PFML policy number

CT PFML insurance carrier's name and mailing address
Standard Insurance Company
PO Box 3877
Portland, OR 97208
866-751-5174 Fax

Declaration and signature

☐ I affirm the employee meets the eligibility for Connecticut Paid Family And Medical Leave.
Under penalties of perjury, I declare that to the best of my knowledge and belief, the information contained herein is true, correct, and complete. Any false statements or other failure to provide truthful, accurate, and complete information may result in monetary and other penalties as well as the possibility of criminal prosecution.

Employer's authorized signature	Date signed (MM/DD/YYYY)

Title

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Connecticut Paid Family and Medical Leave Release of Information for Own Serious Health Condition (Form CT PFML-6)

Notice to the Employee About Use of this Authorization

As you may know, the Connecticut Paid Family And Medical Leave Act (CT PFML) permits an employer or leave administrator to contact an employee's health care provider, with the employee's permission, for the purpose of clarifying or authenticating an otherwise complete and sufficient CT PFML medical certification. For CT PFML purposes, "clarifying" means to understand the meaning of a response or to understand the handwriting and "authenticating" means to provide the health care provider with a copy of the medical certification to verify the information on the form.

To help streamline CT PFML administration and minimize the need to contact you during leave, we have developed the attached CT PFML Authorization. By signing the Authorization, you provide Standard Insurance Company (The Standard) permission to contact your health care provider to clarify and/or authenticate medical certifications under CT PFML. You are not required to complete and sign the Authorization for The Standard to process your request for CT PFML leave. However, completing and signing the Authorization now may shorten the time it takes to clarify or authenticate a medical certification later.

If you decide to sign the Authorization now, you may still revoke it at any time. In addition, before contacting your health care provider to clarify and/or authenticate a medical certification, we will notify you in writing and explain the: (1) specific reason(s) we want to clarify and/or authenticate the certification; (2) information required to clarify and/or authenticate the certification; and (3) time period within which you and/or your health care provider must provide the information needed to clarify and/or authenticate the certification.

If you would like us to authorize now any future CT PFML clarification or authentication, please review the Authorization carefully and complete, sign and return the Authorization to the address above.

I authorize any physician, medical practitioner or healthcare provider (referred to as "health provider") who has completed a medical certification form for ____ (patient name) to discuss with or disclose to STANDARD INSURANCE COMPANY, my health information needed to clarify statements or information provided by health provider on a medical certification form which had been completed by health provider.

- I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct my health provider to release and disclose without restriction information reasonably necessary to clarify or authenticate information provided on a previously completed medical certification form.
- I have the right to refuse to sign this authorization and a right to revoke this authorization at any time by sending a written statement to The Standard, 1100 SW Sixth Avenue, Portland OR 97204, except to the extent the authorization has been relied upon to clarify or authenticate information. A revocation of the authorization, or the failure to sign the authorization, may impair The Standard's ability to evaluate or process the request for leave of absence.
- I understand that in the course of conducting its business The Standard may disclose information to my employer regarding my leave of absence request and status, including a completed return to work authorization form.
- I understand that the information disclosed to The Standard pursuant to this authorization may be subject to redisclosure with my authorization or as otherwise permitted or required by federal or state law. Information retained and disclosed by The Standard may not be protected under the Health Insurance Portability and Accountability Act [HIPAA].
- I understand and agree that this authorization is valid for 12 months from the date signed below.
- A photocopy or facsimile of this authorization is as valid as the original and will be provided to me upon request.

Name (please print)	
Signature of Claimant/Representative	Date

If signature is provided by legal representative (e.g., Attorney in Fact, guardian or conservator), please attach documentation of legal status.

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Connecticut Paid Family And Medical Leave Certification for Own Serious Health Condition (Form CT PFML-7)

Employee's Name	Date of Birth

INSTRUCTIONS for HEALTH CARE PROVIDERS

This form is used to certify a serious health condition in order to qualify for Connecticut Paid Family and Medical Leave (CT PFML). Qualifying serious health conditions and authorized healthcare providers are described below. Answer each question to the best of your medical knowledge, based on your examination of the patient.

SERIOUS HEALTH CONDITION

A "**serious health condition**" is defined as a condition that involves inpatient care or continuing treatment by a health care provider.

- "**Treatment**" includes examinations to determine if a serious health condition exists and evaluations of the condition.
- A "**regime of continuing treatment**" includes, for example, a course of prescription medication (e.g. an antibiotic) or therapy requiring special equipment to resolve or alleviate the health condition.
- It does not include taking of over-the-counter medications such as aspirin, antihistamines, or salves, or bed rest, drinking fluids, exercise, and other similar activities that can be initiated without a visit to a health care provider.
- A person has a "serious health condition" if he/she has one or more of the following conditions summarized below:

Inpatient Care:

- An overnight stay in a hospital, hospice, or residential medical care facility.
- Includes any period of incapacity or any subsequent treatment in connection with the overnight stay.

(*Note: If surgery is elective, and an overnight stay in the hospital is required, leave is covered.*)

Continuing Treatment by a Health Care Provider (*any one or more of the following*)

Incapacity and Treatment: A period of incapacity of more than three consecutive full calendar days, and any subsequent treatment or period of incapacity relating to the same condition, that also involves:

- Two or more in-person visits to a health care provider for treatment within 30 days of the first day of incapacity, unless extenuating circumstances exist. The first visit must be within seven days of the first day of incapacity; or
- At least one in-person visit to a health care provider for treatment within seven days of the first day of incapacity, which results in a regimen of continuing treatment under the supervision of the health care provider.

Examples: the health provider might prescribe a course of prescription medication or therapy requiring special equipment.

Pregnancy: Any period of incapacity due to pregnancy.

Chronic Conditions Requiring Treatments: Any period of incapacity due to or treatment for a chronic serious health condition which:

- Requires periodic visits for treatment by a health care provider at least twice a year; and
- Recurs over an extended period of time; and
- May cause episodic rather than a continuing period of incapacity.

Examples: asthma, migraine headaches, diabetes, epilepsy

Permanent/Long-Term Conditions: A period of incapacity which is permanent or long-term due to a condition for which treatment may not be effective, but which requires the continuing supervision of a health care provider.

"Serious health condition resulting in incapacitation that occurs during a pregnancy" means:

- Prenatal medical appointments
- Pregnancy-related complications
- Recovery from pregnancies that do not end in a live birth
- Childbirth and delivery, and
- The period of time after the delivery during which the biological mother is certified by her doctor to be unable to perform the requirements for her job.

HEALTHCARE PROVIDERS

"Health Care Provider" means:

- A doctor of medicine or osteopathy authorized to practice medicine or surgery by the state in which the doctor practices,
- A podiatrist, dentist, clinical psychologist, or optometrist authorized to practice in the state and performing within the scope of his or her practice;
- A chiropractor authorized to practice in the state and performing within the scope of his or her practice;
- A nurse practitioner, nurse-midwife, clinical social worker, or physician assistant authorized to practice in the state and performing within the scope of his or her practice;
- A Christian Science practitioner listed with the First Church of Christ, Scientist, in Boston, Massachusetts; or
- Any health care provider from whom the employer or the employer's group health plan's benefits manager will accept a medical certification to substantiate a claim for benefits.

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Connecticut Paid Family And Medical Leave Certification for Own Serious Health Condition (Form CT PFML-7)

Employee's Name	Date of Birth

PART A: MEDICAL FACTS

1. Diagnosis: ________________ Primary ICD Code (optional): ________________

   Approximate date condition commenced: ________________ Probable duration of condition: ________________

   Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility? ☐ Yes ☐ No

   If so, dates of admission: ________________

   Date(s) you treated the patient for condition: ________________

   Will the patient need to have treatment visits at least twice per year due to the condition? ☐ Yes ☐ No

   Was the patient referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)? ☐ Yes ☐ No

   If so, state the nature of such treatments and expected duration of treatment: ________________

2. Is the medical condition pregnancy? ☐ Yes ☐ No If so, expected/actual delivery date: ________________
3. Complications with pregnancy or delivery? ☐ Yes ☐ No If yes please explain: ________________
4. Describe other relevant medical facts, if any, related to the condition for which the employee seeks leave (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment): ________________

PART B: AMOUNT OF LEAVE NEEDED

5. Will the employee be incapacitated for a single continuous period of time due to his/her medical condition, including any time for treatment and recovery? ☐ Yes ☐ No

   If so, estimate the beginning and ending dates for the period of incapacity: ________________

6. Will the employee need to attend follow-up treatment appointments or work part-time or on a reduced schedule because of the employee's medical condition? ☐ Yes ☐ No

   If so, are the treatments or the reduced number of hours of work medically necessary? ☐ Yes ☐ No

   Estimate treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including any recovery period: ________________

   Estimate the part-time or reduced work schedule the employee needs, if any:

   __________ hour(s) per day; __________ days per week from ____________ through ____________

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Connecticut Paid Family And Medical Leave Certification for Own Serious Health Condition (Form CT PFML-7)

Employee's Name	Date of Birth

7. Will the condition cause episodic flare-ups periodically preventing the employee from performing his/her job functions? ☐ Yes ☐ No

   Is it medically necessary for the employee to be absent from work during the flare-ups? ☐ Yes ☐ No

   If so, explain:____

   ____

   ____

   ____

   Based upon the patient's medical history and your knowledge of the medical condition, estimate the frequency of flare-ups and the duration of related incapacity that the patient may have over the next 6 months (e.g., 1 episode every 3 months lasting 1-2 days):

   Frequency: ______ times per ______ week(s) ______ month(s)

   Duration: ______ hours or ____ day(s) per episode

ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER.

Health Care Provider's Name			
Address	City	State	ZIP
Phone No.	Fax No.		
Specialty/Type of Practice		License No.	

Declaration and signature

Under penalties of perjury, I declare that to the best of my knowledge and belief, the information contained herein is true, correct, and complete. Any false statements or other failure to provide truthful, accurate, and complete information may result in monetary and other penalties as well as the possibility of criminal prosecution.

Signature of Health Care Provider	Date