



Insurance

Family and Medical Leave
Insurance Program (FAMLI)
COLORADO

Bonding Leave

If you work in Colorado, you can submit a claim for the Colorado Paid Family and Medical Leave Insurance (FAMLI) benefits. Arch Insurance will review all submitted claims to determine your eligibility for benefits. The employee who is applying for leave must complete this certification. This certification will be shared with Arch Insurance and your employer*.

Before you apply for CO FAMLI...



Check eligibility requirements for leave

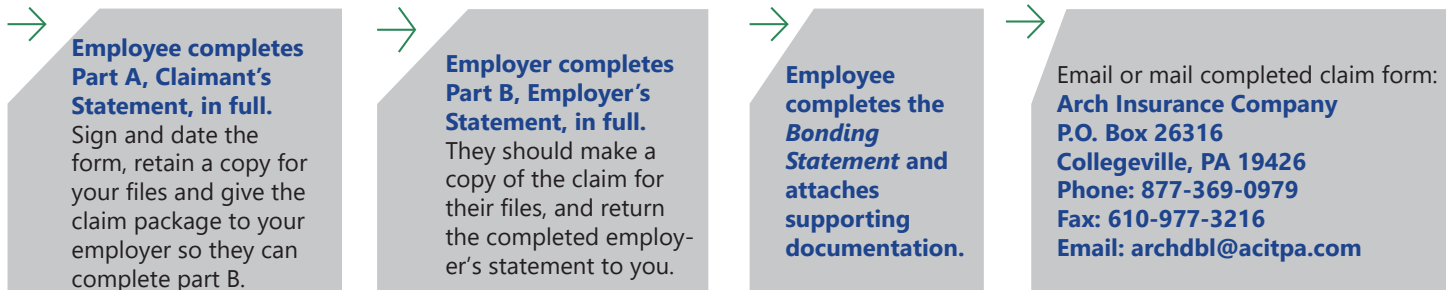


Plan your leave. Leave can be taken continuously (a/k/a block leave), intermittently, or on a reduced leave schedule, in accordance with CO FAMLI.



Notify your CO employer at least 30 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



Application for Colorado Family and Medical Leave Insurance (FAMLI) | Bonding Leave

Part A: Employee Information

(to be completed by the employee requesting leave)

1 **Employee's Legal Name:** _____
(First Name, Middle Initial, Last Name)

2 **Employee's Mailing Address:**

Street _____

Address line 2 _____

City _____ State | ____ | Zip | ____ | ____ | ____ | ____ |

3 **Social Security Number:** ____ - ____ - ____

4 **Employee's Date of Birth:**

m	m	d	d	y	y	y	y
__	__	__	__	__	__	__	__

*Benefits described within are underwritten by Arch Insurance Company, NAIC #11150, a member company of Arch Insurance Group Inc. ("Arch"). Please refer to your policy for detailed terms and conditions. The information you provide to Arch on this form will be used to administer FAMLI benefits. In order to process your claim application, and determine your eligibility and benefit amount, Arch may share your information with your current and/or past employer(s), and FAMLI Partners.

Visit archinsurance.com/disability or call 877-369-0979 for more information.

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Part A Continued

5

Employee's Gender:

☐ Male

☐ Female

☐ Non-Designated / Other

6

Employee's Phone #:

() - | - |

7

Employee's Email Address:

8

Employer Information:

Name

Street

Address line 2

City

State | | Zip | |

Avg # Hours Worked/Week | | Avg # Days Worked/Week | | Avg Wages (\$) | |

8a

List all additional employers from the past year:

Employer #1 Name

Street

Address line 2

City

State | | Zip | |

Period of Employment:

From |

m

m

 / |

d

d

 / |

y

y

y

y

 | To |

m

m

 / |

d

d

 / |

y

y

y

y

 |

Avg # Hours Worked/Week | | Avg # Days Worked/Week | | Avg Wages (\$) | |

Employer #2 Name

Street

Address line 2

City

State | | Zip | |

Period of Employment:

From |

m

m

 / |

d

d

 / |

y

y

y

y

 | To |

m

m

 / |

d

d

 / |

y

y

y

y

 |

Avg # Hours Worked/Week | | Avg # Days Worked/Week | | Avg Wages (\$) | |

Application for Colorado Family and Medical Leave Insurance (FAMLI) | Bonding Leave

Part A Continued

9 Will leave be for a continuous period of time, intermittent and/or reduced?

☐ Continuous Leave Start Date: Leave End Date:

m m d d y y y y m m d d y y y y
| _ _ / | _ _ / | _ _ _ _ | | _ _ / | _ _ / | _ _ _ _ |

☐ Dates are estimated

☐ Intermittent Identify dates intermittent leave will be taken: _____

☐ Dates are estimated _____

☐ Reduced Leave Start Date: m m d d y y y y

| _ _ / | _ _ / | _ _ _ _ |
 Frequency of leave: _____

☐ Dates are estimated

10 Was 30 days Advanced Notice Given to Your Employer for this Leave?

☐ Yes Date notice provided to employer m m d d y y y y

| _ _ / | _ _ / | _ _ _ _ |

☐ No Reason: _____

11 Have you Received or Claimed any of the Following Benefits in the Preceding 52 Weeks?

Benefit Type	Received	Claimed	From (mm/dd/yyyy)	Through (mm/dd/yyyy)
a. Unemployment benefits	☐	☐	_____	_____
b. Workers' Compensation	☐	☐	_____	_____
c. CO FAMLI	☐	☐	_____	_____
d. Other (Sick/Vacation/PTO or other employer provided leave. Please specify.)	☐	☐	_____	_____

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. I further certify that if benefits are paid in excess of the amount to which I am entitled, I will return to the payor of such benefits, the amount that was overpaid, and I acknowledge that failure to do so may result in the accrual of interest and other penalties. I am hereby making a request for benefits under the Colorado 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.

Employee's Signature: _____

Date: m m d d y y y y

| _ _ / | _ _ / | _ _ _ _ |

End of Part A

Questions? Contact us at **877-369-0979**
or find us online at **archinsurance.com/disability**

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Part B: Employer Information

(to be completed by the employer for the above named employee requesting FAMLI)

1 Employer Information:

Business's Full Legal Name: _____

Street _____

Address line 2 _____

City _____ State | ____ | Zip | ____ - ____ - ____ |

Country (if not USA): _____

2 Policy Number: _____

3 Business's Federal Employer Identification Number (FEIN): _____

4 Employer contact person (Name & Title) for this leave request: _____

5 Contact Phone #: (____ - ____) - ____ - ____ - ____ - ____

6 Contact email address: _____

7 Employee's current employment status:

☐ Actively employed-not terminated☐ Terminated from employment — Date termed: ^m ____ ^m ____ / ^d ____ ^d ____ / ^y ____ ^y ____ ^y ____

8 Date employee was hired:

Date: ^m ____ ^m ____ / ^d ____ ^d ____ / ^y ____ ^y ____ ^y ____

9 Last day worked before leave:

Date: ^m ____ ^m ____ / ^d ____ ^d ____ / ^y ____ ^y ____ ^y ____

10 Has the employee returned to work?

☐ Yes ☐ NoReturn to work date: ^m ____ ^m ____ / ^d ____ ^d ____ / ^y ____ ^y ____ ^y ____ ☐ Actual ☐ Estimated

11 Employee's Job Title and Description: _____

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Part B Continued

12 Please check the appropriate boxes:

☐ Exempt
 ☐ Non Exempt
 ☐ Full Time
 ☐ Part Time
 ☐ Hourly
 Hrs/Wk: _____

13 Colorado ("CO") Employment Verification:

- a. Are the employee's earnings reported at year end on IRS form W-2? ☐ Yes ☐ No (answer question 13b)
- b. Is the employee subject to Unemployment Insurance obligations in CO? ☐ Yes ☐ No (answer question 13c)
- c. Is the employee's service localized (performed entirely) within CO? ☐ Yes ☐ No (answer question 13d)
- d. If services are not localized, is the employee's base of operations in CO, and some of the work is performed in CO? ☐ Yes ☐ No (answer question 13e)
- e. If there is no base of operations, does the employee perform some of the services within CO and receive direction and control from CO? ☐ Yes ☐ No (answer question 13f)
- f. If there is no place of direction and control, no localized services and no base of operations in CO, does the employee reside in CO? ☐ Yes ☐ No

14 Select the days of the week the employee usually works:

☐ Monday
 ☐ Tuesday
 ☐ Wednesday
 ☐ Thursday
 ☐ Friday
 ☐ Saturday
 ☐ Sunday

15 Provide the employee's earnings history for the prior 5 completed calendar quarters preceding the request for leave:

Quarter Ending (mm/yyyy)	Gross Wages (\$)

16 Provide the scheduled work hours from the last 4 weeks the employee reported to work prior to the leave:

Week 1 _____
 Week 2 _____
 Week 3 _____
 Week 4 _____
 Average: _____

17 Will leave be utilized continuously or intermittently or on a reduced leave schedule? Provide details below.

Block Leave/Continuous Leave:

 Start date (mm/dd/yyyy) _____ Through (mm/dd/yyyy) _____

Dates requested: _____

Intermittent Leave:

 Frequency of leave: _____
 (eg: 2 days per week, or 4 hours per day, or every Monday)

Reduced Leave Schedule:

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Part B Continued

18 Was 30 days advance given to you by the employee requesting foreseeable leave?

☐ Yes

☐ No

Date notice provided to employer: | / | / | |

19 Has the employee received or claimed any of the following benefits in the preceding 52 weeks?

Benefit Type	Received	Claimed	From (mm/dd/yyyy)	Through (mm/dd/yyyy)
a. Unemployment benefits (CESA)	☐	☐	<u> </u>	<u> </u>
b. Workers' Compensation due to work-related injury/illness	☐	☐	<u> </u>	<u> </u>
c. CO FAMLI	☐	☐	<u> </u>	<u> </u>
d. Other (Sick/Vacation/PTO or other employer provided leave. Please specify.)	☐	☐	<u> </u>	<u> </u>

20 Employer-provided Paid Leave during leave period

An employee cannot receive both wage replacement benefits under the FAMLI Act and employer-provided paid leave for the same hours absent, except that pursuant to C.R.S. 8-13.3-510(1)(c), an employer and an employee may mutually agree that the employee may use any **accrued employer-provided leave** as a **supplement** to family and medical leave insurance benefits in an amount not to exceed the difference between the individual's wage replacement benefits under the FAMLI Act and the individual's average weekly wage.

"**Employer-provided paid leave**" means vacation leave, paid sick leave, paid personal leave, paid parental leave, paid leave under C.R.S. 24-34-402.7, and any other employer-paid time off, except that employer-provided paid leave does not include benefits under a commercial short-term or long-term disability policy for purposes of these rules.

a. Will the employee be using any employer-provided paid leave **during the leave period requested?**

☐ Yes (answer question b) ☐ No

b. Will the employee be receiving wage replacement **during all or a portion of the leave period requested?**

☐ Yes (answer question i and ii) ☐ No

i. provide detail on type of wage replacement and the date(s) it will be paid for:

ii. are you requesting reimbursement* of FAMLI benefits? ☐ Yes ☐ No

Note: Employer reimbursement may be permitted if the employee's salary is being continued through some kinds of benefits payments made by the employer. Employer reimbursement is not permitted if the employee is using any employer-provided paid leave such as use of accrued vacation, sick, personal or parental leave.

Declaration and Signature:

NOTICE: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages.

I am the person authorized to sign as the employer of the employee requesting benefits under the Colorado Family and Medical Leave Insurance program. My signature affirms that to the best of my knowledge the information I have provided is true, accurate, 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: _____

Date: | / | / | |

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Bonding Statement

Important directions for completing your request for benefits:

To request bonding leave benefits under Colorado FAMLI, you must return this completed Family Leave Bonding Statement to us with your completed Application and any other supporting documents. Incomplete or missing information may result in a delay in claim processing.

Section 1: Employee/Applicant Information - For Completion by the Employee

1 **Employee's Legal Name:** _____
(First Name, Middle Initial, Last Name)

2 **Social Security Number:** _____ - _____ - _____

Section 2: Bonding Statement (Statement of the family relationship and bonding type)

1 **I am making a request for paid family leave benefits to bond with:**

Child's Gender: ☐ Male ☐ Female ☐ Non-Designated / Other

Date of Birth, Adoption or Placement: | ^m | ^m | / | ^d | ^d | / | ^y | ^y | ^y | ^y |

2 **Please select one bonding type and submit a copy of the supporting documentation. Please note that additional documentation may be requested as needed:**

- ☐ Biological child - Please provide **one** of the following:
- Proof of birth (copy of birth certificate, application for a birth certificate, documentation from the health care provider who provided care during birth or recovery, or vital records showing birth of child); or
 - Statement from you establishing in loco parentis* status
- ☐ Adopted child - Please provide proof of adoption placement (copy of adoption papers or court documents; include the child's date of birth and adoption date).
- ☐ Foster child- Please provide **one** of the following:
- Proof that you are a licensed or certified foster parent and that the child has been placed in your care; or
 - Documentation from a child placement agency, state or county department of human services, or a court indicating a kinship or emergency placement was necessary to provide for the immediate care and safety of the minor child and you will be standing in loco parentis through a power of attorney or other legal designation.

Employee Signature: _____

Date: | ^m | ^m | / | ^d | ^d | / | ^y | ^y | ^y | ^y |

* In loco parentis – a relationship in which a person puts himself or herself in the situation of parent by assuming and discharging the obligations of a parent to a child. For more details and examples of these relationships, please see 7 CCR 1107-3.