

Family and Medical Leave **Employee's Own** Insurance Program (FAMLI) COLORADO

Health Condition

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*.

	Bef	fore	you	apply	for	CO	FAMLI.	•••
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\bigcirc	Check	eligibility	requirements
for le	eave		

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

Employee completes Part A, 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 part B.

Employer completes Part B, 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.

Provider completes the **Health Care Provider** Certification and attaches supporting documentation.

Email or mail completed claim form: **Arch Insurance Company** P.O. Box 26316 Collegeville, PA 19426 Phone: 877-369-0979 Fax: 610-977-3216 Email: archdbl@acitpa.com

Application for Colorado Family and Medical Leave Insurance (FAMLI) | Employee's Own Health Condition

Employee's Legal Name:(First Name	ne, Middle Initial, Last Name)
Employee's Mailing Address:	
Street	
Address line 2	
City	State Zip
Social Security Number:	

*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.

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

Employee's Gende	: Male Female Non-Designated / Other						
Employee's Phone	#: ()- -						
Employee's Email	Address:						
Date of Disability	m m d d y y y y						
Reason for Medica	I Leave Request:						
Employer Informa	tion:						
Street							
Address line 2							
City							
	Zip ed/Week Avg # Days Worked/Week Avg Wages (\$)						
Avg # Hours Worl	Zip ed/Week Avg # Days Worked/Week Avg Wages (\$) employers from the past year:						
Avg # Hours Worl List all additional Employer #1 Nar	Zip ed/Week Avg # Days Worked/Week Avg Wages (\$) employers from the past year:						
Avg # Hours Worl List all additional Employer #1 Nar Street	Zip ed/Week Avg # Days Worked/Week Avg Wages (\$) employers from the past year:						
Avg # Hours Worl List all additional Employer #1 Nar Street Address line 2	Zip Avg # Days Worked/Week Avg Wages (\$) employers from the past year:						
Avg # Hours Worl List all additional Employer #1 Nar Street Address line 2 City	Zip						
Avg # Hours Worl List all additional Employer #1 Nar Street Address line 2	Zip						
List all additional Employer #1 Nar Street Address line 2 City Period of Employ m n From	Zip						
List all additional Employer #1 Nar Street Address line 2 City Period of Employ From Avg # Hours Wor	Zip						
List all additional Employer #1 Nar Street Address line 2 City Period of Employ m n From	Zip						
Avg # Hours Work List all additional Employer #1 Nar Street Address line 2 City Period of Employ From Avg # Hours Work Employer #2 Nan	Zip						
List all additional Employer #1 Nar Street Address line 2 City Period of Employ From Avg # Hours Wor Employer #2 Nan Street	Zip						
List all additional Employer #1 Nar Street Address line 2 City Period of Employ From Avg # Hours Wor Employer #2 Nan Street Address line 2	Zip ed/Week Avg # Days Worked/Week Avg Wages (\$) employers from the past year: e State Zip nent: Marked/Week Avg Wages (\$) ee Avg # Days Worked/Week Avg Wages (\$) State Zip						

Application for Colorado Family and Medical Leave Insurance (FAMLI) | Employee's Own Health Condition

Application for Colorado Family and Medical Leave Insurance (FAMLI) | Employee's Own Health Condition Part A Continued

Continuous	Leave Start Date m m d d y	y y y 	Leave End Date m m d d /	
	Dates are estimated			
Intermittent	Identify dates intermittent lea	ve will be taken:		
	Dates are estimated	_		
Reduced	Leave Start Date: /	d d y		
	Frequency of leave:			_
	Dates are estimated			
Yes	nced Notice Given to Your Emp Date notice provided to empl	m m	re? ddyyy ' /	
				:
No	Reason:			
	Reason: d or Claimed any of the Followi			
			Preceding 52 Weeks?	Through
Have you Received	d or Claimed any of the Followi	ng Benefits in the	Preceding 52 Weeks?	
Have you Received	d or Claimed any of the Following Received	ng Benefits in the	Preceding 52 Weeks?	Through
Benefit Type a. Unemployment b	d or Claimed any of the Following Received	ng Benefits in the	Preceding 52 Weeks?	Through
Benefit Type a. Unemployment b b. Workers' Compension	Received Denefits Insation Inside or Claimed any of the Following Received Denefits Inside of the Following Received Received Inside of the Following Received	ng Benefits in the	Preceding 52 Weeks?	Through

Date: | ___ / | __ _ / | __ _ _ _ _ |

End of Part A

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

Employer Information: Business's Full Legal Name: Street	Zip
Address line 2 City State Country (if not USA): Policy Number: Business's Federal Employer Identification Number (FEIN): Employer contact person (Name & Title) for this leave request: Contact Phone #: () - -	Zip
Country (if not USA): Policy Number: Business's Federal Employer Identification Number (FEIN): Employer contact person (Name & Title) for this leave request: Contact Phone #: ()	Zip
Country (if not USA): Policy Number: Business's Federal Employer Identification Number (FEIN): Employer contact person (Name & Title) for this leave request: Contact Phone #: () - -	Zip
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Employer contact person (Name & Title) for this leave request: Contact Phone #: () - -	
Employer contact person (Name & Title) for this leave request: Contact Phone #: () - -	
/	
Contact amail address:	
Contact eman address.	
Employee's current employment status:	
Actively employed-not terminated m m d d y y	у у
Terminated from employment — Date termed: / /	1
Date employee was hired:	
m m d d y y y y Date: /	
Last day worked before leave:	
m m d d y y y y Date: /	
Has the employee returned to work?	
Yes No	
m m d d y y y y	

Application for Colorado Family and Medical Leave Insurance (FAMLI) | Employee's Own Health Condition Part B Continued

Please check the appropriate boxes:	
,	
Exempt Non Exempt Ful	Il Time Part Time Hourly Hrs/Wk:
Colorado ("CO") Employment Verification:	
a. Are the employee's earnings reported at year e	end on IRS form W-2?
b. Is the employee subject to Unemployment Inst	surance obligations in CO?
c. Is the employee's service localized (performed	entirely) within CO?
d. If services are not localized, is the employee's and some of the work is performed in CO?	base of operations in CO, Yes No (answer question 13e)
e. If there is no base of operations, does the emp services within CO and receive direction and cont	
f. If there is no place of direction and control, no base of operations in CO, does the employee resi	
Select the days of the week the employee usu	ually works:
Monday Tuesday Wednesd	day 🔲 Thursday 🔲 Friday 🔲 Saturday 🔲 Sunday
Quarter Ending Gross Wages (mm/yyyy) (\$)	Week 1
	Week 2 Week 3
	Week 3
	Week 3 Week 4
	Week 3 Week 4
Will leave be utilized continuously or intermi	Week 3 Week 4 Average: ittently or on a reduced leave schedule? Provide details below.
Will leave be utilized continuously or intermi	Week 3 Week 4 Average: ittently or on a reduced leave schedule? Provide details below. Start date Through
Will leave be utilized continuously or intermi	Week 3 Week 4 Average: ittently or on a reduced leave schedule? Provide details below.
,	Week 3 Week 4 Average: ittently or on a reduced leave schedule? Provide details below. Start date Through
Block Leave/Continuous Leave:	Week 4 Average: ittently or on a reduced leave schedule? Provide details below. Start date (mm/dd/yyyy) (mm/dd/yyyy)

Was 30 days advance given to you be Yes No	by the employe	ae requesting fore		
Yes No		ce requesting fore	seeable leave?	
Date notice provided to employer:	m m /	d d y /	у у у	
19 Has the employee received or claim	ed any of the	following benefits	in the preceding 52 we	eks?
Benefit Type	Received	Claimed	From (mm/dd/yyyy)	Through (mm/dd/yyyy)
a. Unemployment benefits (CESA)				
 b. Workers' Compensation due to work-related injury/illness 				
c. CO FAMLI				
 d. Other (Sick/Vacation/PTO or other employer provided leave. Please specify.) 				
20 Employer-provided Paid Leave during	ng leave perio	d		
al's average weekly wage. "Employer-provided paid leave" mean under C.R.S. 24-34-402.7, and any other efits under a commercial short-term or lea. Will the employee be using any ering any ering yes (answer question b) b. Will the employee be receiving was a Yes (answer question i and ii) i. provide detail on type of	employer-paid ong-term disab nployer-provide No age replacemer	time off, except the oility policy for purpled and leave during all or a p	at employer-provided pai oses of these rules. In the leave period required or the leave period required or the leave period or the leave period required or the leave period or the leave	d leave does not include ben- rested?
ii. are you requesting reim	bursement* of	FAMLI benefits?	Yes No	
Note: Employer reimbursement may be payments made by the employer. Employers expenses such as use of accrued vacation, si	yer reimbursen	nent is not permitte		
Declaration and Signature:				
NOTICE: It is unlawful to knowingly p the purpose of defrauding or attempt and civil damages. I am the person authorized to sign as ical Leave Insurance program. My sign accurate, and complete. Any false state monetary and other penalties as well	the employer on the employer of the affirms the tements or othe	the company. Pena of the employee red hat to the best of n er failure to provide	Ities may include imprison questing benefits under the ny knowledge the informative truthful, accurate and co	nment, fines, denial of insurance ne Colorado Family and Med- ation I have provided is true,
Signature:				

or find us online at archinsurance.com/disability
25-10-DBL23

Colorado - Health Care Provider Certification | Employee's Own Health Condition

Important tips when completing this form

To request Colorado FAMLI benefits, you will need to return this medical certification form. To start, complete **Section 1** and send it to your treating healthcare provider to complete **Section 2** and return to us with your Application and any other supporting documents as part of your claim for benefits.

Section 1: For	Comp	letion by	y the Emp	loyee
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1 Employee's Legal Name:				
	(First Name, Middle Init	tial, Last Name)		
2 Employee's Date of Birth:	m m d d y	. <u>y</u> <u>y</u> <u>y</u>		
3 Employee's Phone #: ()-	_1 -1	I	
4 Employee's Email Address	:			
5 Claim Number (if available	e):			

Section 2: For Completion by the Treating Health Care Provider

Your patient made a request to be absent from work because of their own illness or injury. For us to make a decision on their claim for CO FAMLI benefits, we will need you to complete the information in Section 2. When completing this certification, we ask:

- Your answers are to be your best estimate based on your medical knowledge, experience, and examination of the patient.
- Be as specific as you can. Using terms like "as needed", "unknown" or "indeterminate" may not be enough to approve the claim.
- Limit your responses to the health condition for which your patient is seeking leave. If your patient needs leave due to more than one health condition, please complete a separate certification for each condition.
- Do not include 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 employee's family members, 29 C.F.R. §1635.3(b).

Check the box(es) for the questions below, as applicable. (Options continued on next page)							
	Inpatient Care: The patient (was / is / will be) admitted for an overnight stay in a hospital, hospice, or residential medical care facility on the following date(s):						
	Incapacity plus Treatment: (e.g. outpatient surgery, strep throat)						
	 Due to the patient's health condition, the patient was (was / is / will be) incapacitated for more than three consecutive, full calendar days. 						
	 The patient was (was / is / will be) seen on the following date(s): 						
	• The health condition (had / has / will) also result(ed) in a course of continuing treatment under the supervision of a health care provider (e/g., prescription medication (other than over the counter), therapy requiring special equipment, etc.)						

Colorado - Health Care Provider Certification | Employee's Own Health Condition

Continued **Pregnancy:** The health condition is pregnancy. List the expected delivery date: (mm/dd/yyyy) Chronic Health Conditions: (e.g., asthma, migraine headaches) Treatment visits are expected to be at least twice per year Permanent or Long-Term Health Conditions: Due to the health condition, incapacity is permanent or long term and requires the continuing supervision of a health care provider (even if active treatment is not being provided). Health Conditions requiring Multiple Treatments: (e.g., chemotherapy treatments, restorative surgery, etc.) Due to the health condition, it is medically necessary for the patient to receive multiple treatments. None of the above: If none of the above six categories is checked, (i.e., inpatient care, pregnancy) no additional information is needed. Please sign and date the form. **Diagnosis Code: Diagnosis Description:** First date of disability: Date you first examined the patient for this health condition: Last office visit: **Expected return to work date:** For the health condition for which your patient is requesting time away from work, is it your belief that the health condition was caused by or otherwise related to a workplace injury or illness? No If the employer does not supply a statement of your patient's essential functions or a job description, answer these questions based upon the patient's own description of the essential job functions. An employee who must be absent from work to receive medical treatment(s), such as scheduled medical visits, for a health condition is considered to be not able to perform the essential job functions of the position during the absence for treatment(s). Due to the health condition, my patient (was not able/ Is not able/ will not be able) to perform one or more of the essential job functions(s). Identify at least one essential job function your patient was/is/will be unable to perform:

Colorado - Health Care Provider Certification | Employee's Own Health Condition

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7 Check the applicable box(es) and complete the information that best describes the type of time away from work that the applicant will need for their own health condition.	
	Continuous leave: My patient has/will be incapacitated for a single continuous period due to their own health condition, including time for treatment and recovery beginning/ and ending/
	Reduced Work Schedule leave: My patient will need to work a reduced work schedule due to their own health condition and associated treatment and recovery period beginning/ and ending/ for the following:
	a reduced work day: limited to hours per day;
	a reduced work week: limited to day(s) per week
	Other:
	Intermittent leave - Incapacitation: My patient is expected to have periodic flare-ups where intermittent absence from work will be medically necessary beginning// and ending//
	Describe the estimated frequency and duration of flare-ups. (e.g., 1x per week lasting 4 hours), (e.g., 1x every 3 months lasting 1-2 days), (e.g., 3x every month lasting 1 day). Please select and complete one:
	Weekly:time(s) everyweek(s) for a duration ofhour(s) orday(s) per instance;
	OR Monthly: time(s) everyweek(s) for a duration of hour(s) or day(s) per instance
	Intermittent leave - Treatments: My patient is expected to have periodic flare-ups where intermittent absence from work will be medically necessary beginning// and ending/
	Describe the estimated frequency and duration for treatments/appointments. (e.g., 1 x per week lasting 2 hrs), (e.g., 1 x per month lasting 4 hrs) (e.g., 3x every 2 months lasting 6 hours). Please select and complete one:
	Weekly:time(s) everyweek(s) for a duration ofhour(s) orday(s) per instance;
	OR Monthly: time(s) every week(s) for a duration of hour(s) or day(s) per instance
Health Care Provider Information and Signature Print Treating Health Care Provider Name:	
Specialty/	Board Certification:
Treating H	ealth Care Provider's Business address:
Certification	on License Number: State:
Telephone	:()- -
Fax Numb	er: () - -
Email Add	ress:
Treating Health Care Provider Signature:	
Date: _	m d d y y y y