



Family and Medical Leave
Insurance Program (FAMLI)
COLORADO

Military Exigency 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

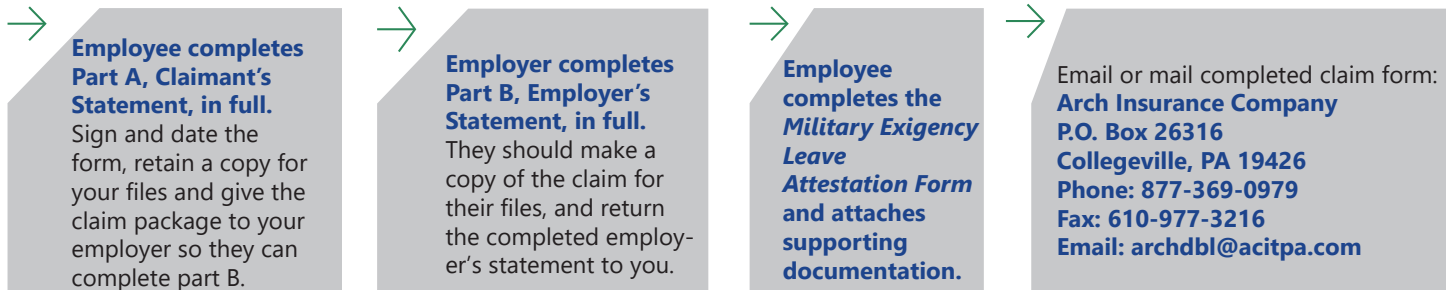


Plan your leave. Leave can be taken continuously (a/k/a block leave), intermittently, or on a reduced leave schedule, in accordance with CO FAMLI.



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) | Military Exigency 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 _ | **To** | ^m _ ^m _ / | ^d _ ^d _ / | ^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 _ | **To** | ^m _ ^m _ / | ^d _ ^d _ / | ^y _ ^y _ ^y _ |

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

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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

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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: | ____ | ____ | / | ____ | ____ | / | ____ | ____ | ____ | ____ |

8 Date employee was hired:

Date: | ____ | ____ | / | ____ | ____ | / | ____ | ____ | ____ | ____ |

9 Last day worked before leave:

Date: | ____ | ____ | / | ____ | ____ | / | ____ | ____ | ____ | ____ |

10 Has the employee returned to work?

☐ Yes ☐ No

Return to work date: | ____ | ____ | / | ____ | ____ | / | ____ | ____ | ____ | ____ | ☐ 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 and supply the number of hours typically scheduled to work each day.

☐ Monday _____ hrs/day
 ☐ Tuesday _____ hrs/day
 ☐ Wednesday _____ hrs/day
 ☐ Thursday _____ hrs/day
 ☐ Friday _____ hrs/day
 ☐ Saturday _____ hrs/day
 ☐ Sunday _____ hrs/day

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

Military Exigency Leave Attestation Form

Section 1: Employee Information - For Completion by the Employee

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

2 Social Security Number: _____ - _____ - _____

Section 2: About the Military Family Member

1 Select the family member to you. The family member is your:

- ☐ Child (of any age) ☐ Spouse ☐ Domestic Partner
- ☐ Parent or your Spouse/Domestic Partner's Parent
- ☐ Sibling or your Spouse/Domestic Partner's Sibling
- ☐ Grandparent or your Spouse/Domestic Partner's Grandparent
- ☐ Grandchild or your Spouse/Domestic Partner's Grandchild
- ☐ Person with whom the employee has a significant bond that is or is like a family relationship

Relationships include: biological, foster, adoptive, step, and in loco parentis relationships and the same relationships to the employee's spouse or domestic partner, if applicable.

2 Family Member's Name: _____
(First Name, Middle Initial, Last Name)

3 Family Member's Mailing Address:

Street _____

Address line 2 _____

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

Section 3: About the Need for Qualified Exigency Leave

If approved, you may take leave for your Family Member's active-duty service or notice of an impending call or order to active-duty in the armed forces. **You must attach to this attestation** a copy of the Family Member's active-duty orders or other documentation issued by the military which indicates that the Family Member is on covered active duty or call to covered active-duty status such as official military correspondence from the military member's chain of command. For each reason checked, please submit supporting documentation or information to expedite processing your claim. We may require other reasonable information or documentation necessary to support your claim.

1 I need leave for the following reason(s). Check all that apply:

- ☐ Providing care or other needs of the military Family Member's Child or ☐ other Family Member
- ☐ Making financial or legal arrangements for the military Family Member.
- ☐ Attending counseling ☐ Attending military events or ceremonies
- ☐ Spending time with the military Family Member during a rest/recuperation leave or after returning from deployment.
- ☐ Making arrangements following the death of the military Family Member.

2 Is written documentation supporting this request for leave available and attached?

☐ Yes ☐ No ☐ None Available

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Military Exigency Leave Attestation Form - Continued

Section 4: Date, Duration and Frequency of Qualified Exigency Leave

Provide information concerning the amount of leave that is needed. Several questions in this section seek a response as to the frequency or duration of the Qualifying Exigency Leave needed. Be as specific as you can; terms such as “unknown” or “indeterminate” may not be sufficient to support paid leave coverage.

If you need differing leave dates/duration/frequency due to more than one qualifying exigency, please provide the information below as to each leave reason. You may use the space below, copies of this page, or additional pages.

1 List the approximate date exigency started or will start: _____
(mm/dd/yyyy)

2 Provide your best estimate of how long the exigency will last. From: _____ to: _____
(mm/dd/yyyy) (mm/dd/yyyy)

Complete items 3,4, and/or 5 as applicable:

3 Due to a qualifying exigency leave, I will need to be absent from work for a continuous period of time. Provide your best estimate of how long the exigency will last. From _____ to: _____
(mm/dd/yyyy) (mm/dd/yyyy)

4 Due to the qualifying exigency, I will need to be absent from work on an intermittent basis (periodically). Provide your best estimate of how often (frequency) you will need to be absent and how long (duration) each appointment, meeting or leave event will last.

From: _____ to _____, I will be absent _____ times per ☐ day/ ☐ week/ ☐ month,
(mm/dd/yyyy) (mm/dd/yyyy)

likely lasting approximately _____ ☐ hours/ ☐ days per episode.

5 Due to a qualifying exigency, I need to work a reduced schedule. Provide your best estimate of the reduced schedule you are able to work.

From: _____ to _____, I am able to work _____ (e.g. 5 hours/day, up to 25 hours a week).
(mm/dd/yyyy) (mm/dd/yyyy)

6 Use this space to provide the information requested in 3, 4, or 5 as to additional exigency leave reasons, if more than one, and/or to provide any additional supporting information:

Section 5: Employee Signature

I attest the information provided above is correct, the documentation I am providing is true and accurate, and I am in need of Qualified Exigency Leave as provided by the Colorado Family and Medical Leave Insurance Act.

Employee Signature: _____

Date: _____

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